Gray Davis, Governor
State of California
Business, Transportation and Housing Agency

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September 13, 2002

IN REPLY REFER TO FILE NO.: 933 0209
Priority Mail

FINAL REPORT

Mr. Howard Davis, Chairman
UNIVERSAL CARE
1600 E. Hill St.
Signal Hill, CA 90806

RE: ROUTINE EXAMINATION OF UNIVERSAL CARE

Dear Mr. Davis:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Universal Care (the "Plan"), conducted by the Department of Managed Health Care (the "Department"), pursuant to Section 1382(b) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on March 11, 2002. The Department received the Plan's response on March 25, 2002 to Section II. Calculation of Tangible Net Equity, which required a response within five working days from the date of the Preliminary Report. The Department issued a Follow-up Preliminary Report to this response on April 12, 2002 and received the Plan's response on April 19, 2002. The Department received the Plan's response to the remaining issues in the Preliminary Report on April 29, 2002 and received revised financial projections on May 1, 2002.

The Department performed a review to verify the representations made by the Plan in its responses noted above. The Department engaged an outside consultant (the "Contractor") to perform the review. This review was limited in scope, as it focused on the calculation of the total claims liability, the calculation of required tangible net equity ("TNE"), a review of the calculation of TNE compliance, and the review of projections for the period ended March 31, 2002. The Contractor performed this nonroutine examination during the period May 14, 2002 through June 30, 2002.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

This Final Report includes a description of the compliance efforts included in the Plan's March 25, 2002, April 19, 2002, April 29, 2002 and May 1, 2002 responses, as well as the findings from the Department's review, in accordance with Section 1382(c).

Section 1382(d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the final report. If so, please indicate which portions of the Plan's response shall be appended, and provide copies of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382(c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its March 25, 2002, April 19, 2002, April 29, 2002 or May 1, 2002 responses, please provide the documentation no later than ten (10) days from the date of the Plan's receipt of this letter.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter

As noted in the attached Final Report, the Plan's responses did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on March 11, 2002. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the report. If the Plan fails to fully respond and/or resolve the deficiencies raised in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

The Executive Summary to the Department's most recent Medical Survey Report is located at the Department's website www.dmhc.ca.gov.

If there are any questions regarding this report, please call.

Sincerely,

Joan Larsen
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

cc: Jay Davis, Vice President of Universal Care
Andrew Meyers, Assistant Deputy Director, Office of Health Plan Oversight
Mark Wright, Chief, Division of Financial Oversight
Lisa Medina, Financial Examiner
Warren Barnes, Chief, Division of Licensing
Roslyn Mack, Counsel
Amy Dobberteen, Counsel, Office of Enforcement
Marie Vann, Chief, Division of Plan Surveys
Cheri Rice, Medi-Cal Managed Care Division, Department of Health Services

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION

UNIVERSAL CARE

FILE NO.: 933 0209

DATE OF FINAL REPORT: SEPTEMBER 13, 2002

EXAMINER IN CHARGE: JOAN LARSEN
EXAMINER STAFF: NED GENNAOUI, SHELLEY TANG AND MARTHA VILLEGAS

BACKGROUND INFORMATION FOR UNIVERSAL CARE

Date Plan Licensed:	October 15, 1985
Organizational Structure:	Universal Care is a for-profit California corporation and is wholly owned by Howard E. Davis. Universal Care provides administrative services to an affiliate, Universal Care of Tennessee, Inc. and is also affiliated with Universal Care Health Systems, Inc., a corporation owned by Howard E. Davis and various family members.
Type of Plan:	Full-service health care service plan that also provides dental and optometric care.
Provider Network:	The Plan is a mixed model plan having both staff model and contracted provider networks. The Plan owns and operates approximately 9 staff model medical facilities, 9 pharmacies, 2 optometric facilities and 14 dental offices. The staff model providers are compensated by salary. The contracted providers are paid on a capitated or fee-for-service basis; hospitals are paid on a per diem basis; specialists are paid reduced fee-for-service. Incentives are provided to contracting providers through risk-sharing arrangements.
Plan Enrollment:	355,670 enrollees for the quarter ended June 30, 2002, which includes 178,307 Medi-Cal beneficiaries.
Service Area:	Los Angeles, Orange, Riverside, San Bernardino, San Diego, Kern and Ventura counties.
Date of last Public Routine Financial Examination Report:	May 20, 1998

FINAL REPORT OF A ROUTINE EXAMINATION OF UNIVERSAL CARE

This is a Final Report of a routine examination of the fiscal and administrative affairs of Universal Care (the "Plan"), conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382(b) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on March 11, 2002.

The Department received the Plan's response on March 25, 2002 to Section II. Calculation of Tangible Net Equity, which required a response within five working days from the date of the Preliminary Report. The Department issued a Follow-up Preliminary Report to this response on April 12, 2002 and received the Plan's response on April 19, 2002. The Department received the Plan's response to the remaining issues in the Preliminary Report on April 29, 2002 and received revised financial projections on May 1, 2002.

The Department performed a review to verify the representations made by the Plan in its responses noted above. The Department engaged an outside consultant (the "Contractor") to perform this review. This review was limited in scope, as it focused on the calculation of the total claims liability, the calculation of required tangible net equity ("TNE"), a review of the calculation of TNE compliance, and the review of projections for the period ended March 31, 2002. The Contractor performed the review during the period May 14, 2002 through June 30, 2002.

This Final Report includes a description of the compliance efforts included in the Plan's March 25, 2002, April 19, 2002, April 29, 2002 and May 1, 2002 responses, as well as the findings from the Department's review, in accordance with Section 1382(c).

We examined the financial report filed with the Department for the year ended June 30, 2001, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. Our findings are presented in this report as follows:

Section I.	Financial Statements and Explanation of Adjustments
Section II.	Tangible Net Equity (TNE) Calculation
Section III.	Tangible Net equity and Financial Viability
Section IV.	Compliance Issues

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

A. BALANCE SHEET – AS OF JUNE 30, 2001

	Reported per F/S @ 6/30/01		Examination Adjustments Debit		Credit	Examination Balance @ 6/30/01
CURRENT ASSETS						
Cash	$ 8,758,849					$ 8,758,849
Short-Term Investments	415,147					415,147
Premiums Receivables - Net	18,224,489					18,224,489
Interest Receivable	10,235					10,235
		A3	383,357			
Other Receivables – Net	9,508,411	A4	3,157,239			13,049,007
Prepaid Expenses	1,564,807					1,564,807
Aggregate Write-Ins - Current	1,354,191					1,354,191
TOTAL CURRENT ASSETS	$ 39,836,129		3,540,596			$ 43,376,725
OTHER ASSETS						
Restricted Assets	500,000					500,000
Intangible Assets and Goodwill	0	R1	5,121,138			5,121,138
Leasehold Improvements-Net	771,881					771,881
AggregateWrite-ins-Noncurrent	5,628,442			R1	5,121,138	507,304
TOTAL OTHER ASSETS	6,900,323		5,121,138		5,121,138	6,900,323
PROPERTY & EQUIPMENT						
Land	5,099,723					5,099,723
Building & Improvements	8,133,916					8,133,916
Construction in Progress	46,010					46,010
Furniture & Equipment	4,768,048					4,768,048
Rounding	1					
TOTAL PROPERTY & EQUIP	18,047,698					18,047,697
TOTAL ASSETS	$ 64,784,150		$ 8,661,734		$5,121,138	$ 68,324,746

A. BALANCE SHEET (continued)

	Reported per F/S @ 6/30/01	Examination Adjustments Debit		Credit	Examination Balance @ 6/30/01
CURRENT LIABILITIES					
Accounts Payable	12,020,864				12,020,864
Claims Payable	8,012,725				8,012,725
Accrued Inpatient Claims	13,404,226		R2	474,000	
			A1	9,213,253	23,091,479
Accrued Physician Claims	619,066				619,066
Accrued Other Medical	424,317				424,317
Accrued Medical Incentive Pool	6,414,470	A2 612,200			
		R2 474,000			5,328,270
Unearned Premiums	2,652,062				2,652,062
Loans & Notes payable-current	850,831				850,831
TOTAL CURRENT LIABILITIES	44,398,561	1,086,200		9,687,253	52,999,614
OTHER LIABILITIES					
Loans & Notes Payable-Long term	9,159,790				9,159,790
Aggregate Write-Ins – Other	2,657,960				2,657,960
TOTAL OTHER LIABILITIES	11,817,750				11,817,750
TOTAL LIABILITIES	$56,216,311	1,086,200		9,687,253	$ 64,817,364
NET WORTH					
Capital	26,000				26,000
Paid in Surplus	186,487	R3 147,087			39,400
Unassigned Surplus	8,355,352				8,355,352
Adjustments forwarded from Section I-B Income Statement		9,213,253		4,152,796	<5,060,457>
Aggregate Write-Ins			R3	147,087	147,087
TOTAL NET WORTH	8,567,839	9,360,340		4,299,883	3,507,382
TOTAL LIAB. & NET WORTH	$64,784,150	10,446,540		13,987,136	$68,324,746

B. INCOME STATEMENT

STATEMENT OF INCOME AND EXPENSES
FOR THE YEAR ENDED JUNE 30, 2001

	Reported per F/S @ 6/30/01	Examination Adjustments Debit		Examination Adjustments Credit	Examination Balance @ 6/30/01
REVENUES					
Premium Revenue	$ 170,765,881				$ 170,765,881
Fee-for-Service	4,577,927				4,577,927
Co-payments	1,396,032				1,396,032
Title XVIII-Medicare	211,554				211,554
Title XIX-Medicaid	166,767,472				166,767,472
Interest	1,006,977				1,006,977
Aggr Write-Ins for Other Rev.	249,291				249,291
TOTAL REVENUE	$ 344,975,134				$ 344,975,134
HEALTH CARE EXPENSE					
			A2	612,200	
Medical Services	316,434,484	A1 9,213,253	A3	383,357	324,652,180
TOTAL HEALTH CARE EXPENSE	316,434,484	9,213,253		995,557	324,652,180
ADMINISTRATION					
Administrative Expenses	32,769,868				32,769,868
TOTAL ADMINISTRATION	32,769,868				32,769,868
TOTAL EXPENSES	$ 349,204,352	9,213,253		995,557	$ 357,422,048
PRETAX INCOME (LOSS)	<4,229,218>	9,213,253		995,557	<12,446,914>
PROVISION FOR TAXES	1,513,735		A4	3,157,239	4,670,974
NET INCOME (LOSS)	$<2,715,483>	9,213,253		4,152,796	$<7,775,940>

C. EXPLANATION OF EXAMINATION ADJUSTMENTS

ADJUSTING JOURNAL ENTRIES

AJE #	ACCOUNT NAME	DEBIT	CREDIT
A1	Medical Expense	$9,213,253	
	Accrued Claims Liability		$ 9,213,253

To increase claim reserves (Accrued Claims) based upon claim payment information, subsequent to 6/30/01 for service dates prior to that period.

A2	Accrued Medical Incentive Pool	$ 612,200	
	Medical Expense		$ 612,200

To reduce incentives accrued for surplus risk pools related to increase in claim reserves.

A3	Reinsurance Receivables	$ 383,357	
	Medical Expense		$ 383,357

To accrue for reinsurance receivables for date of services June 30, 2001 and prior for reimbursements received in December 2001 to March 2002.

A4	Income Tax Refund Receivable	$3,157,239	
	Tax Benefit		$3,157,239

To record the tax effect resulting from the above adjusting journal entries.

RECLASSIFYING JOURNAL ENTRIES

R1	Intangible Assets & Goodwill	$5,121,138	
	Aggregate Write-ins Other Assets		$ 5,121,138

To present intangible assets on the correct line of the Orange Blank form.

R2	Accrued Medical Incentive Pool	$ 474,000	
	Accrued Inpatient Claims		$ 474,000

To reclassify a year-end audit adjustment to properly accrue for surplus risk pools for additional claim reserves that was incorrectly recorded to Accrued Inpatient Claims.

R3	Accum. Other Comprehensive Income	$ 147,087	
	Paid in Surplus		$ 147,087

To reclassify unrealized gain or loss on marketable securities as other comprehensive income instead of Paid in Surplus.

The Preliminary Report required the Plan to provide assurance to the Department that the above adjustments were posted to the books or provide an explanation regarding their disposition.

The Plan's response stated that it recorded the adjusting entries to increase its claims liability (A1), reduce its shared risk incentive liability (A2), recognize certain reinsurance receivables (A3) associated with the increased claims liability, and recorded the tax benefit adjusting entry (A4) during fiscal year 2002, the period in which the changes were identified and quantified, in accordance with APB No. 20.

The Department finds that the compliance effort, as set forth above, responds to the corrective action cited by the Department. The Plan filed revised statutory financial statements for the year ended June 30, 2001 with the Department, which reflects these adjusting and reclassification entries.

Section II. CALCULATION OF TANGIBLE NET EQUITY (TNE)-*Repeat Deficiency*

Net Worth per Examination at June 30, 2001 (from Section I. A.)	$ 3,507,382
Add: Subordinated Debt	877,934
Less: Intangible Assets	<5,121,138>
TNE Position at June 30, 2001	$ < 735,822>
REQUIRED TNE under POS per Examination	7,244,340
TNE DEFICIENCY at June 30, 2001	$ < 7,980,162>

The Plan is in violation of Rule 1300.76 that requires each plan to maintain TNE at least equal to the specified minimum amounts at all times. The Plan is also in violation of the increased TNE requirement as required by Section 1374.64(b)(2)(A)(i)(II) due to the Plan offering point-of-service (POS) contracts.

Failure of a Plan, that offers POS contracts, to maintain adjusted TNE as determined by Section 1374.64(b)(2) shall be required to file monthly reports under Rule 1300.84.3(d). Section 1374.64(d) allows the Director, by written order, to direct the plan to discontinue offering POS contracts if it appears the Plan does not have sufficient financial viability.

The Plan currently files monthly reports pursuant to Rule 1300.84.3(d) and was required to continue to do so. The Preliminary Report required the Plan to discontinue offering POS contracts due to the Plan's failure to comply with the TNE and working capital requirements under the provisions of Section 1374.64, and the Departments serious concerns about the Plan's financial viability (see Section III. of this report). The Plan was required to contact the Department's licensing Counsel regarding the unwinding of the POS product and transitioning of the enrollees.

The Preliminary Report required the Plan to confirm, within five (5) working days after receipt of the report, that the TNE deficiency of $ 7,980,162 at June 30, 2001 had been

corrected. All applicable documentation necessary to provide sufficient evidence that the deficiency was corrected must be submitted.

Although Section 1382 provides for a forty-five (45) working day response for the purpose of confidentiality, due to the significance nature of this noncompliance a timelier response was warranted. Therefore, a response to Section II. was required within five (5) working days after receipt of the Preliminary Report.

The Preliminary Report also required the Plan to describe the procedures which have been implemented to assure the Department that the Plan will maintain adequate TNE at all times as required by Rule 1300.76. The Plan was required to disclose the action taken in regards to unwinding the POS product under Section 1374.64(b) and the transitioning of the enrollees. The Plan was to include with its response a copy of any filing made with the Department. In addition, the Plan was to state the date of implementation of those procedures, the responsible management position, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Department acknowledged in the Preliminary Report the receipt of the following amendment filings from the Plan in its effort to correct the above TNE deficiency:

- October 22, 2001 filing amended on February 22, 2002 regarding the subordination of $2,500,000 in debt
- February 27, 2002 filing regarding the infusion of assets and the subordination of related debt of $4,540,000.

The Department acknowledges in this report that the Plan filed additional amendments to the February 27, 2002 filing on May 1 and 16, 2002. The Department issued a letter on June 24, 2002 approving the above subordinated debt total of $7,040,000.

The Plan responded that it wishes to reiterate that the Department's presentation of TNE as of June 30, 2001 was adjusted for claims data, which became available subsequent to the audit report date that represents a change in estimate, pursuant to APB No. 20. In accordance with APB No. 20, the Plan stated that it recorded the change in estimate in the accounting period in which the change was identified and quantified. Upon recognizing a TNE shortfall, the Plan stated that it immediately secured additional subordinated debt to satisfy its TNE requirement.

The Department stated in its Follow-up Preliminary Report that it reviewed APB No. 20. The Department discussed with the Plan and its independent auditors that our review of claims paid data determined that the Plan has understated its claims liability as far back as the quarter ended March 31, 2000 (see Section IV. C. 1. of this Report). The Department is of the position that this understatement of claims liability would have been discovered had the Plan and its independent auditors performed hindsight reviews of paid claims data and compared it with the estimated claims liabilities reported on an interim financial statement basis during the fiscal year ended June 30, 2001. The Department considers that this information was available to the Plan and its independent auditors, but was not used. Therefore, the

Department's adjustment for this under accrual of claims was to be considered a correction of an error, which requires restatement of the financial report for the fiscal year ended June 30, 2001. In addition, the Department brought this information to the attention of the Plan and its independent auditors, as soon as it was determined. Although this notification was subsequent to the date of the audited report, the Plan and its independent auditors did investigate this under accrual of the claims liability and agreed with the Department's findings. In fact, the independent auditors determined a higher under accrual of the claims liability than the Department for the year ended June 30, 2001. Due to this material understatement of the claims liability, the audited report for the fiscal year ended June 30, 2001 does not fairly present the claims liability. As a result, the Department cannot place reliance upon this audit report and the public reviewing this audit report have not been properly informed. (Reference to SAS No. 1, Section 561 and APB 20).

The Follow-up Preliminary Report required the Plan to revise the financial statements and the auditor's report for the fiscal year ended June 30, 2001. The Plan was reminded that the Department rejected the financial statements and audit report pursuant to Section 1384(h) in our letter dated December 18, 2001. A revised audit report was not filed with the Department as required. The Plan was informed that its failure to comply with this requirement was referred to the Department's Office of Enforcement for appropriate administrative action.

The Plan responded that its independent accounting firm met with the Department to discuss the provisions of APB No. 20. During this meeting, the Plan's independent accounting firm concluded that the adjustment to the claims liability represented a change in estimate and that the firm's Partner concluded that the firm was precluded from restating the Plan's audited financial statement. The Partner also consulted with the firm's National Office, which concluded that the increase to the claims liability represents a change in estimate. The Partner further informed the Plan that the firm was precluded from considering evidence that occurred subsequent to the report date and materiality is not considered under the provision of APB No. 20. The Plan stated that it concurs with its independent accounting firm's interpretation of APB NO. 20. However, the Plan responded that to satisfy the Department's request the Plan proposes to amend its June 30, 2001 statutory filing. The Plan stated that this option was discussed with the Chief of the Division of Financial Oversight and that an agreement was reached to accept an amended statutory filing for June 30, 2001 to reflect adjusted claims data available through December 31, 2001.

The Plan further stated that it wishes to emphasize that the audited financial statements for the fiscal year ended June 30, 2001 were based upon data available as of the report date, which included a certified actuary's review of IBNR. To the extent the Department computed an amended TNE as of June 30, 2001, the Plan believes all subsequent events, including the additional subordinated debt, must be considered.

The Plan provided a copy of its amended IBNR Policy & Procedures, which includes a retrospective review of IBNR based upon paid claims. The Plan stated it believes the changes to its IBNR Policy & Procedures will improve the Plan's estimate of IBNR and

facilitate ensuring proper presentation of its financial statements. The Plan also provided a copy of a Policy & Procedure developed to ensure proper presentation of its statutory filings.

The Plan provided a roll forward calculation of net worth from June 30, 2001 to February 28, 2002 in its response. The Plan stated that this roll forward calculation included the additional subordinated debt submitted to the Department for approval and disclosed a TNE Excess of $982,535.

The Plan responded that pursuant to Section 1374.64 an "adjusted" POS TNE shortfall requires the Plan to file monthly financial statements or other actions determined by the Director. The Plan is currently filing monthly financial statements with the Department. Furthermore, the Plan stated that it has limited financial exposure based upon the physician only out-of-network benefit offering under the POS product design.

The Department finds that the compliance effort, as set forth above, is responsive to the deficiency cited and the corrective action required by the Department. However, the subordinated debt of $7,040,000 as approved by the Department on June 24, 2002 was not adequate to cure the total TNE deficiency of $7,980,162 as at the year ended June 30, 2001.

As a result of the review for the period ended March 31, 2002, the Contractor determined that the Plan had incorrectly calculated the required TNE for the quarter ended March 31, 2002. The Plan reported required TNE of $7,920,370 and the Contractor calculated required TNE of $9,363,484. This difference was mainly due to a mathematical error by the Plan. The Plan also incorrectly included subordinated debt that had not yet been approved by the Department in its calculation of TNE for the quarter ended March 31, 2002 and month ended May 31, 2002. As a result of these findings, the Plan has a TNE deficiency for the quarter ended March 31, 2002 and the month ended May 31, 2002, as follows:

	March 31, 2002	May 31, 2002
Net Worth as Reported by Plan	$ 6,277,645	$ 6,986,496
Add: Subordinated Debt*	499,517	499,517
Less: Intangible Assets	<4,843,427>	<4,781,713>
TNE Position	$ 1,933,735	$ 2,704,300
REQUIRED TNE under POS per Examination	9,363,484	
REQUIRED TNE without POS, as reported by Plan		9,376,511
TNE <Deficiency>	**$ <7,429,749>**	**$<6,672,211>**

*subordinated debt of $7,040,000 was approved by the Department on June 24, 2002 and may not be reflected in the Plan's calculation of TNE until the month ended June 30, 2002. (see Section III.A. of this report.)

The Plan was still in a TNE deficient position at the month ended May 31, 2002, due to the subordinated debt of $7,040,000 not approved by the Department until June

24, 2002. However, the Plan's quarterly report for June 30, 2002, as filed with the Department, reports compliance with the TNE requirements, as follows:

	June 30, 2002
Net Worth as Reported by Plan	$ 7,095,065
Add: Subordinated Debt*	7,539,517
Less: Intangible Assets	<4,750,856>
TNE Position	$ 9,883,726
REQUIRED TNE under POS	9,792,049
TNE Excess	**$ 91,677**

Due to the seriousness of the TNE violation, it was referred to the Office of Enforcement.

REPEAT DEFICIENCY

A TNE deficiency was also reported in our Confidential Report of Examination Findings dated June 20, 1997, following our prior examination for the period ended September 30, 1996. This TNE deficiency was a result of numerous examination adjustments necessary to fairly present the Plan's interim financial statements.

Although the adjustments at the prior examination are different from this examination, the Preliminary Report dated March 11, 2002 required the Plan to state the measures taken to ensure proper presentation of the financial statements and the measures taken to prevent further recurrence of noncompliance in this area.

The Plan responded that in connection with the Department's prior routine regulatory examination of the Plan's fiscal and administrative operations as of September 30, 1996 no actions were requested from the Department or required of the Plan to satisfy its TNE requirements. On July 1, 1998 the Plan responded to the Department's September 30, 1996 regulatory audit. The Plan noted in its response that as of July 1, 1998 the Plan had sufficient income from operations to satisfy its TNE requirement.

The Department finds that the Plan's response is not responsive to the corrective action cited by the Department. The Plan is again required to state the measures taken to ensure proper presentation of the financial statements and the measures taken to prevent further recurrence of noncompliance in this area.

SECTION III. TANGIBLE NET EQUITY AND FINANCIAL VIABILITY

A. TANGIBLE NET EQUITY (TNE)

Section 1376 states that each plan shall have and maintain TNE equal to an amount that is calculated based upon requirements set forth in Rule 1300.76. Rule 1300.76(e) states that the required amount of TNE must be maintained at all times. Rule 1300.76(a) also sets forth the method for determining the required amount of TNE that shall be maintained at all times.

The Plan incorrectly reported excess TNE in its quarterly reports for the period June 30, 2001 through December 31, 2001, due to the following:

- medical liabilities were under accrued in all periods presented below, see Section IV.C.1.of this report.

- included subordinated debt for an original note of $430,000 with balance of $87,756 at June 30, 2001 that our examination disclosed had not been filed with and approved by the Department.

- included additional subordinated debt of $2,500,000 and $9,000,000 for the periods ended June 30, 2001 through December 31, 2001, respectively that had not been approved by the Department.

- Calculation of required TNE was prepared incorrectly under the annualized premium revenue method for periods September 2001 and prior. The Plan did not properly complete the calculation under the annualized health care expenditures method in its supplemental information that accompanies its quarterly report filings with the Department. As a result, our examination resulted in a higher required TNE for the period ended June 30, 2001. The Plan determined its required TNE pursuant to the annualized health care expenditures method under Rule 1300.76(a)(3) for the period ended December 31, 2001.

As a result of the above, the Plan did **not** comply with the TNE requirements from June 30, 2001 through December 31, 2001, as shown below:

	QE6/30/01	QE9/30/01	QE12/31/01
Net Worth*	$8,567,839	$9,544,913	$5,186,093
Add: Subordinated Debt*	3,465,691	3,216,395	9,499,517
Less: Intangible Assets*	5,121,138	5,028,568	4,935,997
TNE*	$6,912,392	$7,732,740	$9,749,613
Required TNE*	4,660,056	5,379,282	7,728,472
TNE Excess*	$2,252,336	$2,353,458	$2,021,141
Add: reduction to Accrued Medical Incentive Pool due to increased medical liability (AJE#A2 from Section I)	612,200	612,200	0
Less: Unapproved Subordinated Debt	2,587,757	2,544,315	9,000,000
Less: Medical Liability Adjust+	$9,213,253	$9,042,540	$1,553,540
Less: Additional Required TNE	2,584,284	ND	ND
REVISED TNE <DEFICIENCY>	<11,520,758>	<8,621,197>	<8,532,399>

* As reported by plan
+ AJE#A from Section I for 6/30/01. Per examination review of medical claims liability for 9/30/01and 12/31/01, see Section IV.C.1. below.
ND=not determined

Due to the substantial under accrual of the claims liability and the significant impact on the Plan's TNE compliance had this liability been properly reported, the Preliminary Report required the Plan to refile its financial statements for the fiscal year ended June 30, 2001 and the quarters ended September 30, 2001 and December 31, 2001. These submissions were to be labeled "revised". These revised financial statements were to report the revised medical liability and any additional adjustments to the financial statements were to be supported by narrative explanation. The supplemental information that accompanies these reports was to be revised to include the proper calculation of the required TNE pursuant to Rule 1300.76(a)(3) and only subordinated debt that has been filed and approved by the Department within the time period being reported upon is to be presented in the calculation of TNE compliance. The Plan may include a footnote reference regarding the corrective action being taken to correct the resulting TNE deficiencies. These revised statements were to be submitted to the Department's

Sacramento address within forty-five (45) working days after receipt of the Preliminary Report and copies of such statements were to be included with the Plan's response to the Preliminary Report.

The Plan provided the following responses in regards to the Department's bullet points presented above:

- *The Plan reiterated that the adjusting entries included in the Preliminary Report, which resulted in the TNE shortfall, are based upon a retrospective review of claims data through December 31, 2001. The claims data became available subsequent to the issuance of the Plan's audited financial statements for the fiscal year ended June 30, 2001. The audited financial statements were based upon information available as of the report date.*

  The filings for the quarters ended June 30, 2001 and September 31, 2001 reported the claims liability and excess TNE based upon the audited estimate at the time of filing. For the quarter ended December 31, 2001 the Plan's claims liability was adjusted within the estimated range reviewed by an Independent Actuary, which included a retrospective review of the claims liability as of June 30, 2001 based upon claims data through December 31, 2001. The Plan's December 31, 2001 TNE calculation included additional subordinated debt filed with the Department. The Plan's amended filings will include a retrospective calculation of TNE and claims liability.

- *As noted above, the Plan increased its claims liability during fiscal year 2002 immediately upon identifying and quantifying the under accrual. Upon recognizing a TNE shortfall, the Plan immediately secured additional subordinated debt to satisfy its TNE requirement. The Plan immediately filed the additional subordinated debt with the Department. Copies of the subordinated debt filing were included in the Plan's response.*

  The Plan's June 30, 2001, September 30, 2001 and December 31, 2001 statutory filings included footnote notations identifying the additional subordinated debt as pending the Department's approval. The Department requested additional documentation supporting the additional subordinated debt, which the plan provided. The Plan requested the Department to approve the additional subordinated debt prior to May 1, 2002.

- *The Plan will ensure that all subordinated debt is filed with the Department. The subordinated debt referenced above has been paid in full.*

- *The Plan computed required TNE using Method B of the statutory filing. The Plan has computed IBNR under Method B historically, which has been reviewed and approved by the Department in connection with prior examinations. Management believed this method yielded the greater of Methods A, B, and C and is widely used within the industry. The Plan agrees to compute Method C in determining required TNE.*

The Plan further responded that the adjusting entries included in the Preliminary Report are based upon a retrospective review of claims data through December 31, 2001. The Plan stated that claims data became available subsequent to the issuance of the Plan's audited financial statements for the fiscal year ended June 30, 2001. The Plan's June 30, 2001, September 30, 2001 and December 31, 2001 statutory filings were presented based upon data available at the time of issuance, which included a review of IBNR by a Certified Actuary.

The Plan stated that it's June 30, 2001, September 30, 2001 and December 31, 2001 statutory filings include a footnote notation indicating that the TNE calculation included subordinated debt, which required department approval.

With respect to the Department's request to revise its financial statements for the fiscal year ended June 30, 2001 and the quarters ended September 30, 2001 and December 31, 2001, the Plan stated that it's independent accounting firm is precluded from restating audited financial statements pursuant to APB. No. 20. A copy of a letter from the Plan's independent accounting firm stating its position was provided by the Plan within its response. The Plan concurs with its independent accounting firm's interpretation of APB No. 20.

In order to satisfy the Department's request, the Plan provided the Department with pro forma amended statutory filings for the fiscal year ended June 30, 2001 and the quarters ended September 30, 2001 and December 31, 2001. The Plan stated that these amended financial statements would be filed with the Plan's March 31, 2002 quarterly filing. The filings will be labeled "amended" and include a reconciliation of net equity from the reported statutory filings to the "amended" statutory filings. The Plan provided copies of the "amended" filings with its response.

The Plan presented the following based on these amended reports:

	QE 6/30/01	*QE 9/30/01*	*QE 12/31/01*	*02/28/2002 As Reported*
Net Worth	*$3,507,382*	*$3,952,241*	*$5,182,797*	*$6,026,474*
Add: Subordinated Debt	*965,691*	*716,395*	*499,517*	*499,517*
Less: Intangible Assets	*5,121,138*	*5,028,568*	*4,935,997*	*4,874,484*
TNE	*$(648,065)*	*$(359,932)*	*$746,317*	*$1,651,707*
Required TNE	*5,933,390*	*6,110,659*	*7,323,171*	*7,709,172*
TNE Excess (Deficit)	*$(6,581,455)*	*$(6,470,591)*	*$(6,576,854)*	*$(6,057,465)*
Add: Subordinated debt-Pending Department approval	*2,500,000*	*2,500,000*	*2,500,000*	*2,500,000 3,000,000 1,540,000*
Amended TNE Excess (Deficit)	*(4,081,455)*	*(3,970,591)*	*(4,076,854)*	*982,535*

The Department finds that the compliance effort, as set forth above, is responsive to the deficiency cited and the corrective action required by the Department. However, the "revised" financial statements as filed by the Plan on April 29, 2002 were not executed and dated. The Department required the Plan to refile executed financial statements, which were received on May 8, 2002.

B. FINANCIAL VIABILITY

Section 1375.1 requires every licensed plan to demonstrate that it has a fiscally sound operation and adequate provision against the risk of insolvency. Rule 1300.75.1 requires that every plan demonstrate fiscal soundness and assumption of full financial risk through its history of operations, projections, provide for the achievement and maintenance of a positive cash flow, including provision for retirement of existing and proposed indebtedness, and adequate working capital, including provision for contingencies.

The Department has concerns regarding the Plan's ability to demonstrate a fiscally sound operation and adequate provision against the risk of insolvency, as follows:

1. As noted in paragraph A of this Section, the Plan substantially under accrued its claims liability for the entire fiscal year ending June 30, 2001 and the quarters ended September 30, 2001 and December 31, 2001, which also resulted in the Plan incorrectly reporting TNE compliance when it was actually in a deficit position.

Therefore, the Plan's ability to comply with TNE requirements is of significant concern.

2. As presented in Section I. of this report, the Plan has current assets of $43,376,725 as of June 30, 2001. The current assets consist of cash of $9,173,996, which is not adequate to cover the Plan's current liabilities of $52,999,614. The current assets minus the current liabilities results in negative working capital of <$9,622,889>. Therefore, the Plan does not demonstrate adequate working capital as required by Rule 1300.75.1 or by the POS requirement in Section 1374.64(b)(2).

3. The Plan has failed to maintain sufficient cash and short term investments to cover its current obligations as described below:

	QE 12/31/00*	QE 3/31/01*	QE 6/30/01*	QE 9/30/01*	QE12/31/01*
Cash & Short Term Investments	$5,166,043	$ 7,910,510	$ 9,173,996	$ 9,439,750	$ 9,755,931
Current Liabilities	33,709,318^	36,401,422^	44,398,561^	46,990,116^	52,907,918
Excess Liabilities Over Cash and Short Term Investments	$<28,543,275>	$<28,490,912>	$<35,224,565>	$<37,550,366>	$<43,151,987>

* As originally reported to the Department
^ Does not include under accrual of claims liability, see Section IV.C.1. of this report

4. Another measure of liquidity is the current ratio, which is current assets divided by current liabilities. As a result of examination adjustments, the Plan's current ratio is .82:1 at June 30, 2001. The Plan reports an improved current ratio of .85:1 at December 31, 2001.

5. The Plan reported negative cash flows from operations of <$2,246,118> for the year ended June 30, 2001. The Plan reports positive cash flows from operations of $1,273,595 and $836,239 for quarters ended September 30, 2001 and December 31, 2001, respectively.

6. As a result of examination adjustments, the Plan is in a net loss position of <$7,775,940> for the year ended June 30, 2001. The Plan reported a net loss of <$3,381,739> for the six months ended December 31, 2001. However, the Plan's net loss at December 31, 2001 included the prior period adjustment for additional claims liability for June 30, 2001 that has been reflected by the Department at June 30, 2001.

7. The Plan continued to make payments on subordinated debt held by three officers of the Plan through December 31, 2001, even though the Plan was in a TNE deficient position. The balance of these notes was $378,417, $172,563 and $0 as at June 30, 2001, September 30, 2001 and December 31, 2001, respectively.

8. Our examination included a limited review of the financial statements for Universal Care Health Systems (UCHS), an affiliate of the Plan, for the period ended September

30, 2001. We determined that this interim report could not be relied upon. However, the financial statement disclosed financial viability concerns, as UCHS's cash position of $464,153 is not adequate to cover its current liabilities of $784,575. UCHS reports negative working capital of <$320,422>, a current ratio of .59:1, and no net income (revenue equals expenses). The Department is uncertain as to the financial impact that this entity could have on the Plan. (See comments under Section IV.A. of this report.)

As discussed in Section II. of this report, the Department received an amendment filing on February 27, 2002 regarding additional subordinated debt for an infusion of $4,540,000 in assets to the Plan from its officers. These assets were to consist of $3,000,000 in cash and real estate valued at $1,540,000. While this additional subordinated debt moves towards the correction of the TNE deficiency at June 30, 2001, the Department notes that the infusion of real estate will not improve the Plan's cash position or the financial viability concerns addressed above.

The Preliminary Report required the Plan to provide a corrective action plan that will result in an adequate demonstration of financial viability with specific disclosure as to the steps taken to improve its cash/liquidity position. This demonstration must include the changes made, the procedures put in place, and the management position responsible for ensuring fiscal soundness and compliance with Section 1375.1 and Rule 1300.75.1 at all times. The Plan's response was to include, but not be limited to, the cash management policies and procedures for the Plan.

In addition, the Preliminary Report required the Plan to provide a description of each management initiative undertaken to improve its operational performance. The description was to include the specific dollar amount related to or to be achieved by implementing each management initiative, the date as to when each management initiative was or will be implemented, and the date of completion.

Furthermore, the Preliminary Report required the Plan to file monthly financial projections for one year and quarterly projections for one additional year. These projections must include a balance sheet, statement of income and expense, and statement of cash flows prepared in accordance with generally accepted accounting principles. They were to also include enrollment information, capital funding needs, affiliate transactions, TNE and administrative cost calculations for each month and quarter. These projections were to be accompanied by all assumptions which are necessary to support the projections, including a description of the marketing program and documentation of all sources of capital funding needed to ensure compliance with the TNE requirements of Rule 1300.76 at all times.

The projections were to begin with the historical financial statements for the quarter ended December 31, 2001, as revised pursuant to the request under paragraph A above, and should be based upon, and agree with, these statements. The projections should also reflect the management initiatives requested above, the adjusting journal and reclassification entries noted in Section I of this report and include the service area

expansions that were recently filed with the Department, as well as the financial impact of entering the Medicare market through the Center for Medicare and Medical Services contract effective March 1, 2002.

The Plan provided the following responses in regards to the Department's numbered paragraphs presented above:

1. *As previously noted, the adjusting entry included in the Preliminary Report to increase the claims liability resulted in the TNE short fall. The adjusting entry was determined by a retrospective review of claims data through December 31, 2001. The claims data became available subsequent to the issuance of the Plan's audited financial statements for the fiscal year ended June 30, 2001. The audited financial statements were based upon information available as of the report data. The Plan immediately secured additional subordinated debt to meet its TNE requirement.*

2. *A significant portion of the Plan's non-cash current assets convert to cash during the first week following month end. Accounts receivables include a monthly payment of $13 million received during the first week following month end in connection with the Plan's Los Angeles County Medi-Cal contract. The significant balance in the Plans commercial premiums receivables also turn in less than 30 days. A significant portion of the Plan's current liabilities is not settled within a 30-day period. The IBNR claims liability accrual includes a reserve for claims, which has not been received by the Plan. The Plan's total claims liability approximates $34.5 million of which 32% or $11 million is satisfied within 30 days and 68% or $23.5 million) is received 30 days beyond the date of service; this represents 41% of the Plan's total current liabilities. The Plan has sufficient cash and cash equivalents to meet its current obligations. As of February 28, 2002 the Plan has quick assets (convertible to cash within 30 days of $37.7 million and current liabilities requiring settlement within 30 days of $26.0 million demonstrated as follows:*

As of February 28, 2002 (in millions)

Current Assets		***Current Liabilities***	
Cash	*$ 15.9*	*Accounts Payable*	*$14.8*
Receivables Collected within 30 days:			
Medi-Cal receivables	*15.0*	*Claims payable (<30 Days)*	*11.0*
Premium receivables	*4.9*	*Note Payments*	*00.2*
Fee-for-Service	*1.9*		
Subtotal quick assets	*37.7*	*Current Liabilities paid less than 30 days*	*26.0*
Other current Assets	*18.0*	*Other current Liabilities*	*32.3 (a)*
Total current Assets	*$ 55.7*	*Total Current Liabilities*	*$ 58.3*

(a) *Includes unearned premiums, notes payable, risk share incentives, certain accruals and claims liabilities settled beyond 30 days.*

3. *As illustrated in the Plan's response to #2 above, the Plan has sufficient cash and cash equivalents to met current obligations as they become due.*

4. *As of February 28, 2002 the Plan reported a current ratio of .95:1, which is slightly below 1:1. The Plan is current on all its obligations, including claims payable and trade payables. Taking into consideration the Plan's adjustments the June amended current ratio was .82:1. Since its inception, the Plan has not experienced cash flow issues that have impaired its ability to satisfy current obligations. During fiscal year 2002 the Plan's cash positions has increased 90% from $8.8 million as of June 30, 2001 to $15.9 million as of February 28, 2002, and $16.7 million as of March 31, 2002. The Plan forecasts continued increases in cash and cash equivalents from operations and anticipate achieving a current ratio of 1:1 during fiscal year 2003. In addition, the Plan is a mixed model Health Plan that owns a considerable amount of real estate. The medical buildings appraise at values exceeding their existing encumbrances and can be sold or refinanced in the event the Plan requires additional non-operating cash flows. A schedule of the Plan's real estate holdings was included in its response with an estimated equity of approximately $7 million.*

5. *The Plan concurs that its operating cash flows have continued to improve during fiscal year 2002. As noted in the Plan's response to #4 above, during fiscal year 2002 the Plan's cash position has increased 90% from $8.8 million as of June 30, 2001 to $15.9 million as of February 28, 2002, and $16.7 million as of March 31, 2002. The Plan forecasts continued increases in cash and cash equivalents from operations and anticipate achieving a current ratio of 1:1 during fiscal year 2003.*

6. *As noted in the Plans response to Section I of the Preliminary Report, the Plan recorded the adjusting entries during fiscal year 2002. The adjusting entries are included in the Plan's fiscal year 2002 operating results for the six-month period ended December 31, 2001. The amounts reported by the Department above include the adjusting entries (A1 and A2) in fiscal year 2001, instead of fiscal year 2002. The Plan's amended calculation for the six-months ended December 31, 2001 results in pretax income of $2,555,260 and after tax net income of $1,230,559.*

7. *As previously noted, the increase to the claims liability which resulted in the TNE shortfall was based upon claims data that became available subsequent to the report date of the audited financial statements for the fiscal year ended June 30, 2001. The Plan filed its June 30, 2001, September 30, 2001 and December 31, 2001 statutory filings based upon information available at the time of filing, which demonstrated compliance with TNE. The Plan's payments on the referenced notes occurred during the normal course of business. The Plan contributed sufficient additional subordinated debt immediately upon identifying and quantifying the additional capital required to satisfy TNE.*

8. *Universal Care Health Systems provided administrative support to the Plan under a cost reimbursement arrangement. This entity did not generate income or experience losses. The amounts reported above required certain reclassification entries. The Department was provided with updated unaudited financial statements that reported a cash balance of approximately $464,000 and a corresponding liability to the Plan for $464,000. The balance sheet amounts represented a payroll advance. As of March 31, 2002, the Plan's management services arrangement with Universal Care Health System terminated. The result of this transaction will have no financial impact to the Plan's operating results and TNE.*

The Plan further responded that it developed a Corrective Action Plan subsequent to the issuance of its June 30, 2001 audited financial statements. The Plan has updated its Corrective Action Plan to reflect current operating results, changes in service area, changes in product offering, cash flows, cash management and changes to its IBNR Policy & Procedure. A copy of the current Corrective Action Plan was provided in the Plan's response. This Corrective Action Plan provides monthly financial projections for one year and quarterly projections for one additional year including the information requested.

The Plan responded that the real estate purchased by the Plan and secured by subordinated debt adds value to the Plan. The Plan stated it has a tangible value that can be sold or refinanced in the event the Plan requires additional non-operating cash flows.

The Department finds that the compliance effort, as set forth above, is not fully responsive to the deficiency cited and the corrective action required by the Department, as follows:

- As part of the review performed by the Contractor, they reviewed the projections for the period ended March 31, 2002 and determined that certain lines of business are not profitable (i.e., possible loss contracts). Therefore, the Department still has significant concerns regarding the Plan's on-going profitability and the Plan's ability to demonstrate continued financial viability.

- The Department reviewed the financial reports filed by the Plan for each month ended and quarter ended January 31, 2002 through June 30, 2002 and disclosed that the Plan incorrectly reports $1,300,000 of its total claims liability as long-term. The Plan's reporting of this portion of its total claims liability as long-term understates the Plan's current liabilities and results in an overstatement of the Plan's current ratio and working capital position for each of these time periods.

- The Plan did not include disclosure of the procedures put in place and the management position responsible for ensuring continued compliance with the financial viability requirements.

- The Plan did not provide a description of each management initiative undertaken to improve its operational performance. This description was to include the specific dollar amount related to or to be achieved by implementing each management initiative, the date as to when each management initiative was or will be implemented and the date of completion.

The Plan is again required to provide a corrective action plan that will result in an adequate demonstration of financial viability and compliance with Section 1375.1and Rule 1300.75.1. This corrective action plan is to address the bullet points above. The Plan is also required to demonstrate that it considers the proper accounting for loss contracts, as required under FASB Statement No. 5, Accounting

for Contingencies, in the preparation of its financial statements filed with the Department. [Reference to "Accounting for Loss Contracts" in paragraphs 13.05 and 13.06 of the AICPA Audit and Accounting Guide for Health Care Organizations dated May 1, 1999]

The Plan is also required to report all claims liability in the appropriate claim line item of the "current liabilities" in its financial statement filings made with the Department, beginning with the month ended August 31, 2002.

The Plan's response to paragraph 7 above, states that its statutory financial statements for the periods June 30, 2001, September 30, 2001 and December 31, 2001 demonstrated compliance with TNE and that the payments on the subordinated debt occurred during the normal course of business. The Department disagrees with the Plan's response. As noted in Sections I. and II.A. of this Report, the Plan actually had TNE deficiencies during these time periods, but had incorrectly included additional subordinated debt that was not approved by the Department until June 24, 2002. The subordinated debt on the books at June 30, 2001 and subsequent time periods is not considered to be normal course of business type debt. The subordination agreements for this debt clearly set forth that payment is not to be made if the Plan does not comply with the TNE requirement. The Plan's audited annual financial statements for the year ended June 30, 2001 were filed with the Department on October 31, 2001. Therefore, the Plan had adequate knowledge in the month of October 2001 that it was in a TNE deficient position and that subordinated debt was not to be paid.

The Plan is again required to provide the policies and procedures that have been implemented to ensure that its recently approved subordinated debt will not be paid if the Plan would be in a TNE deficient position. The Plan is to state the date these policies and procedures were implemented and the management position responsible for compliance.

Section IV. COMPLIANCE ISSUES

A. ADMINISTRATIVE CAPACITY

Section 1367(g) requires a plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. Rule 1300.67.3(a)(2) requires the plan to have staffing in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

To demonstrate adequate administrative capacity, a plan must have executive management and support staff sufficient to perform the necessary administrative functions of a health care service plan. A plan may make contractual arrangements for non-discretionary or ministerial services, but a Plan employee must perform functions requiring the exercise of any judgment, or decision-making, with the Plan's management having the ultimate responsibility. Furthermore, any non-discretionary functions that are delegated must be performed with oversight by the Plan's management.

Our examination disclosed that the Plan did not have administrative capacity as required by Section 1367(g) and Rule 1300.67.3(a)(2).

The deficiencies noted throughout this report demonstrate a failure on the part of Plan management to understand its obligations to comply with the financial and compliance requirements placed on the Plan by the Knox-Keene Health Care Service Plan Act of 1975 ("Act") and the California Code of Regulations ("Rules").

The following are examples of the Plan's lack of administrative capacity:

1. The Plan relinquished control of a majority of its administrative functions of Plan operations, including accounting and claims processing, to an affiliate, Universal Care Health Systems (UCHS), without prior filing with and approval from the Department.

2. The Plan's CFO and key management staff over the claims process, as well as a majority of the employees of the Plan, were transferred to UCHS on January 21, 2001, but were not operationally effective until July 1, 2001. However, this transfer of personnel took place without prior filing with and approval from the Department.

3. A draft Administrative Service Agreement between the Plan and UCHS was filed with the Department on August 31, 2001. A revised agreement was filed with the Department on November 1, 2001, after comments issued by Department Counsel. The filing with the Department was made after UCHS became operational on July 1, 2001.

4. Delegated services provided to the Plan by UCHS are performed without adequate oversight by the Plan's executive or key management staff.

5. The Plan provides administrative services to an affiliate, Universal Care of Tennessee, without benefit of an Administrative Service Agreement.

6. The Plan conducted some minor business transactions with an affiliate, Dental Management Associates, without benefit of an Administrative Service Agreement.

7. The Plan substantially understated its medical liabilities and, as a result, overstated its TNE position in its financial statement filings for the fiscal year ended June 30, 2001 and the quarters ended September 30, 2001 and December 31, 2001, as discussed previously in this report. The Department has concerns regarding the accounting staff's knowledge and ability to calculate the accrued medical liabilities.

8. Our examination included a limited review of the financial statements for Universal Care Health Systems (UCHS) for the period ended September 30, 2001, which determined that this interim report could not be relied upon. The CFO for UCHS originally provided a financial statement that disclosed a receivable from an officer and stockholder's equity. When support was requested for these balances, the CFO provided a revised financial statement removing these accounts. The CFO was also uncertain about the proper presentation of the transfer of accrued vacation from the Plan to UCHS, as it was recorded as an "other asset", as well as a liability. The financials also disclosed financial viability concerns, as discussed in Section III. B. above.

9. Restricted deposits under Section 1374.68 and Rule 1300.76 were withdrawn and a substitute deposit made without approval of the Department. Both deposits were combined and placed into one bank account without proper assignment forms. (See Section IV.E. of this report)

10. Board of Director minutes did not support the following:

    - Authorization of check signors
    - Discussion or approval to transfer staff to UCHS effective 1/21/01
    - Discussion or approval to enter into administrative arrangements with UCHS or Universal Care of Tennessee.

The Preliminary Report required the Plan to provide a detailed Corrective Action Plan ("CAP") to bring the Plan in compliance with Section 1367(g) and Rule 1300.67.3(a)(2). The CAP was to include the following elements:

- All Plan employees are to be brought back into the Plan and placed on the Plan's payroll no later than March 31, 2002.

- Administrative service agreements contemplated by the Plan must be filed with and approved by the Department PRIOR to their implementation.

- Administrative service agreements considered between the Plan and an affiliate is to be specific regarding the services to be performed by the Plan or affiliate. Any services provided to the Plan are to be ministerial in nature and must state how the Plan will provide oversight for each delegated activity and how the performance of this oversight will be documented. In addition, the compensation arrangements should be fully disclosed and the Plan is to demonstrate that the compensation is fair and reasonable to the Plan and relates to the services provided.

- Administrative service agreement is to be executed between the Plan and each affiliate that the Plan provides services on behalf of or receives services from.

- A demonstration that Plan's executive and key management staff has adequate knowledge and understanding of the Act and Rules.

- A demonstration that the Plan has a Board of Directors that is actively involved in the financial and operational issues of the Plan.

The Preliminary Report required the Plan to state the date on which all employees were returned to the Plan. The Plan was also required to state the date any administrative services contracts were filed with the Department and include a copy of such filing with its response to this report. The CAP provided was to address the examples cited above and provide time frames for compliance for any corrective action that may take longer than the 45-day response time to this report.

The Plan provided the following responses in regards to the Department's numbered paragraphs presented above:

1. *The Plan filed an amendment to the UCHS filing on March 25, 2002. A copy of the filing was included with the Plan's response. The purpose of the Amendment filing was to demonstrate that the Plan made significant changes to its relationship with UCHS. As of March 31, 2002 and effective retroactively to January 1, 2002, UCHS no longer employs Plan personnel. All administrative personnel are employed by the Plan and under the direct control of the Plan. As a result of this transaction, the administrative capacity concerns addressed in the Preliminary Report have been satisfied.*

2. *As noted in the Plan's response to #1 above, all Plan personnel have been transferred back to the Plan effective retroactive to January 1, 2002.*

3. *This matter has been satisfied with the transfer of Plan personnel back to the Plan effective retroactive to January 1, 2002.*

4. *The Plan's executive and management staff did provide oversight of UCHS services. The transfer of Plan employees to UCHS did not impact employee functions and management oversight. Further, the Plan did not experience any services issues under the UCHS arrangement. The transfer served principally as an accounting transaction. As previously noted, Plan employees have been transferred back to the Plan effective retroactive to January 1, 2002.*

5. *The Plan filed its Administrative Services Agreement with Universal Care of Tennessee, Inc. with the Department. A copy of the filing was included with the Plan's response.*

6. *The Plan filed its Administrative Services Agreement with Dental Management Associates with the Department. A copy of the filing was included with the Plan's response.*

7. *The Plan revised its IBNR Policy & Procedure to ensure that events, which impact its estimate of IBNR, are identified on a timely basis. The principal changes include a retrospective review of claims paid subsequent to the reporting period and engaging an Independent Certified Actuary to perform a periodic review of IBNR. A copy of the revised IBNR Policy & Procedure was included with the Plan's response. The Plan believes that the changes to its IBNR Policy & Procedures will ensure more*

accurate estimates of the claims liability and timely recognition of business events which impact the IBNR estimate.

8. *The financial statements of Universal Care Health Systems were not included in the Department's initial audit request. The Plan provided the Department with financial statements for the initial three months ended September 30, 2001. The financial statements reflected original entries, which required certain reclassification adjusting entries. It is common business practice to require adjusting entries and reclassification entries to the accounting records during month end closing procedures. Such entries may require analysis of accounting transactions. Such analysis does not reflect uncertainty. Upon recording the appropriate reclassification entries, the Plan provided the Department with revised financial statements, which reported cash of approximately $464,000 and a corresponding liability to the Plan for $464,000. As previously noted, UCHS provided administrative services to the Plan under a cost reimbursement arrangement. As discussed with the Department, the entity did not generate income or experience losses. The entity did not experience financial risk. The financial statement's presented did not disclose financial viability concerns.*

9. *The Plan maintained a restricted deposit with the Director in the amounts of $300,000 and $200,000, respectively, in a combined investment account with its bank. The Plan has provided the Department with the original and one copy of each assignment form supporting the separate assignment of each deposit with its response. The Plan's Chief Financial Officer will ensure that an assignment form will be completed and provided to the Department upon maturity of any restricted deposit investments.*

10. *There have been no recent changes to the authorized check signers of the Plan. The Plan will ensure that the Board will approve any changes to the authorized check signers. The Plan's Board members are actively involved in the day-to-day operations and approve all significant contractual arrangements. The Plan will ensure that all significant contracts are documented and approved by the Board.*

Furthermore, the Plan stated that its Executive Committee would ensure that all administrative services agreements are filed with and approved by the Department prior to implementation. The Plan's Executive Committee, which consists of top executive staff active in the day-to-day business activity of the Plan, will ensure that an administrative services agreement is executed for all affiliate arrangements.

The Plan stated that the amendment to the UCHS filing on March 25, 2002 referenced above, included the Administrative Agreement with an affiliate, Universal Care of Tennessee, Inc. This Administrative Services agreement describes the services performed, the Plan's oversight provisions, and the compensation arrangements. The amendment filing was provided with the Plan's response.

The Plan stated that its executive and key management staff has a thorough knowledge and understanding of the Act and Rules.

The Plan stated that all of the Plan's Board members are active employees of the Plan and participate in all significant operational issues of the Plan.

The Department finds that the compliance effort, as set forth above, is responsive to the deficiency cited and the corrective action required by the Department. However, the Department has the following concerns with the Plan's response:

1. The Department disagrees with the Plan's statement within its response to paragraph 8 above. The Plan did not provide the Department with a revised financial statement for the period ended September 30, 2001 that reflected reclassification entries resulting in only the presentation of cash and corresponding liability of $464,153 for UCHS. As also addressed in paragraph 8 of Section III. B. of this Report, UCHS financial statement provided to the Department also disclosed an "other asset" and corresponding liability for $320,422.

   The Plan is required to provide a copy of the financial statements for UCHS for the quarter ended September 30, 2001 to support the Plan's response.

2. The Plan stated that its executive and key management staff has a thorough knowledge and understanding of the Act and Rules, but did not provide a demonstration of this as previously required by the Department. As noted in Section IV. E. of this report, the Plan does not have a full understanding of Section 1374.68(a) and Rule 1300.76.1. Also, the Plan did not properly execute or complete its financial statement filings to the Department as discussed in Section III. A, C.1. and F. of this report.

   The Plan is again required to demonstrate that the Plan's executive and key management staff has adequate knowledge and understanding of the Act and Rules.

B. MATERIAL MODIFICATIONS AND AMENDMENTS

Section 1352(a) and (b), and Rules 1300.52 and 1300.52.1 require all plans to file an amendment with the Director within thirty (30) days after any change in the information contained in its application, other than financial and statistical. Material changes to the Plan's operation are required to be filed as a Notice of Material Modification twenty (20) days prior to any changes being implemented as specified in this Section and Rules.

Our examination disclosed that the Plan receives and/or provides administrative services to/from the following entities that were not supported by a written agreement or an agreement that was filed with the Department (See Section IV.A. for related comment):

Universal Care of Tennessee
Dental Management Associates

The Preliminary Report required the Plan to review their administrative arrangements with each of the above affiliates and enter into an administrative service agreement with each entity that is performing services for the Plan and with each entity for which the Plan provides

services. The arrangements described in the agreements should include the elements noted in corrective action requested in Section IV.A. of this report. These agreements are to be filed as an amendment with the Department, in accordance with the Section and Rule stated above.

The Preliminary Report required the Plan to provide evidence (i.e., a copy) in its response to this report that the requested filing has been submitted to the Department within forty-five (45) days after receipt of this report. The cover page for this amendment filing should state that it is filed as a result of the recent financial examination.

Furthermore, the Plan was required to state the management position responsible for ensuring that all administrative arrangements are supported by a written administrative agreement and provides a description of the monitoring system implemented to ensure ongoing compliance with the Section and Rule stated above.

The Plan responded that it filed the administrative services agreement with Dental Management Associates and Universal Care of Tennessee, Inc. with the Department. Copies of the administrative services agreements were included in the Plan's response. The Plan stated that its Executive Committee would ensure that all administrative arrangements are supported by written agreements and that all such arrangements will require approval by the Executive Committee.

The Department finds that the compliance effort, as set forth above, is responsive to the deficiency cited and the corrective action required by the Department.

The Department received the amendment filing, reference above, on March 25, 2002 and it is currently under review.

C. CLAIMS

1. CLAIMS LIABILITY

Rule 1300.77.2 requires a plan to calculate the estimate of incurred and unreported claims pursuant to a method held unobjectionable by the Director. The amount required by Rule 1300.77.1 to be accrued in the plan's books and records must equal the estimated total of all claims incurred but not yet received as of the end of the month as calculated in working papers, schedules or reports prepared in support of the method.

As part of our examination, the Department performed a hindsight analysis of the Plan's reported medical claims liability using paid claims data for the period November 1998 through January 2002. Our evaluation of the claims liability was conducted as of quarter ended March 31, 2000 through quarter ended December 31, 2001. At our request, the Plan hired an actuary and recalculated the claims liability using this paid claims data for the fiscal year ended June 30, 2001 and the quarter ended December 31, 2001. An adjusting journal entry was necessary to properly state the claims liability at June 30, 2001, see adjustment A1 and reclassification entry R2 in Section I. of this report.

As determined by the Department, the Plan's medical claims liability was significantly understated for the periods presented below:

	Claims Liability Per Examination	Claims Liability Reported by Plan	Under Accrual
QE 3/31/00	$20,100,640	$ 9,499,575	$10,601,065
QE 6/30/00	$20,943,245	$10,978,001	$ 9,965,244
QE 9/30/00	$21,205,486	$10,186,404	$11,019,082
QE 12/31/00	$25,159,659	$13,567,473	$11,592,186
QE3/31/01	$27,347,382	$13,633,646	$13,713,736
QE 6/30/01	$32,147,587	$22,460,334	$ 9,687,253
QE 9/30/01	$32,206,640	$23,164,100	$ 9,042,540
QE 12/31/01	$35,744,909	$34,191,369	$ 1,553,540

The Department also reviewed the methodology the Plan used to calculate the claims liability. The Plan uses received claims data to estimate its Incurred But Not Reported (IBNR) claims and calculates its claims payable (claims received but not yet paid) separately. Although such methodology is acceptable under Rule 1300.77.2, the Department noted that the completion factors used in the Plan's lag study for IBNR were not reflective of the historical trend developed from the paid claims data for the period November 1998 to January 2002—the Plan was using too short of a completion period and did not appear to be reviewing this estimate with actual paid data.

The Preliminary Report required the Plan to perform hindsight analysis of its claim liability using paid claim data. The Plan was required to provide a detailed description of the procedures it has implemented to ensure that a proper accrual for IBNR claims liability is reported in its financial statements filed with the Department. The Plan was also required to submit a hindsight analysis report and work papers that support the total claims liability reported in each financial statement submitted to the Department, beginning with the quarterly report as of March 31, 2002. Such supporting documentation is to be filed until such time as the Department notifies the Plan that they may be discontinued.

Furthermore, the Plan is required to state the management position responsible for the calculation and recording of the IBNR liability and for ensuring continued compliance with Rules 1300.77.1 and 1300.77.2.

The Plan responded that it claims liability under accrual was identified as a result of a retrospective review of claims data through December 31, 2001, subsequent to the issuance of the June 30, 2001 audited financial statements. Historically the Plan experienced a (12) month claims run-out period. The claims liability under accrual is

principally attributed to the claims run-out extending beyond the historical twelve-month period.

The Plan has revised its IBNR Policy & Procedures to ensure that events, which impact its estimate of IBNR, are identified on a timely basis. The principal changes include a retrospective review of paid claims data subsequent to the reporting period and engaging an Independent Actuary to perform a periodic review of IBNR. A copy of the revised IBNR Policy & Procedure was provided in the Plan's response. The Plan agrees to provide the Department with documentation supporting its calculation of IBNR and a hindsight analysis report with the March 31, 2002 statutory filing.

The Plan's IBNR will be reviewed and approved by the Chief Financial Officer and the Chief Operations Officer.

The Department finds that the compliance effort, as set forth above, is not fully responsive to the corrective action required by the Department.

The Plan did not submit a hindsight analysis report and work papers that support the total claims liability reported with the quarterly financial statements for March 31, 2002 and June 30, 2002 as submitted to the Department. In addition, Schedule I-Analysis of Total Medical Liability to Actual Claims Paid submitted with the Plan's quarterly filing for March 31, 2002 was not completed for paid claims.

The Plan is again required to submit this hindsight analysis report and work papers for the quarter ended March 31, 2002 and June 30, 2002 with its response to this report. In addition, for <u>all future quarterly filings</u> a hindsight analysis report and work papers are to be an attachment to the electronic filings made to the Department beginning with the quarter ended September 30, 2002. The Plan is also required to state what action it has taken to ensure that the financial statement filings made to the Department are properly completed, as directed by the Department. (See related discussion in Section II. and III.B. of this report.)

The Department reviewed the Plan's monthly and quarterly filings since the quarter ended December 31, 2001, as filed with the Department, and presents the total claims liability as reported by the Plan for these periods, as follows:

ME 1/02	$ 34,254,146
ME 2/02	$ 34,184,749
QE 3/02	$ 34,348,335
ME 4/02	$ 37,892,045
ME 5/02	$ 34,124,263
QE 6/02	$ 36,690,982

The Department disclosed material fluctuations in the total claims liability reported by the Plan for the months ended April 30, 2002, May 31, 2002 and the quarter ended June 30, 2002, as presented above, and emphasized by underlines. The total claims liability for the month ended April 30, 2002 reflects a material increase of approximately 10% from the quarter ended March 31, 2002. However, the Plan reports a material decrease of approximately 10% in the total claims liability reported for the month ended May 31, 2002 and again reports a material increase of approximately 8% in the total claims liability for the quarter ended June 30, 2002.

As a result of the above material fluctuations, the Department has concerns that the total claims liability is properly presented as of May 31, 2002 and as to whether the Plan is properly calculating its total claims liability in its monthly financial statements.

The Plan is required to provide an explanation of the material fluctuations in the total claims liability for the periods ended April 30, 2002, May 31, 2002 and June 30, 2002, as noted above; and, demonstrate that its monthly financial statements are reporting the total claims liability in a manner consistent with its quarterly and annual financial statements filings.

2. CLAIMS REIMBURSEMENT-*Repeat deficiency*

Section 1371 requires a health care service plan to reimburse claims or any portion of any claim, as soon as practical, but no later than 45 working days after the receipt of the claim, unless the claim or portion thereof is contested or denied by the plan. If an uncontested claim is not reimbursed within the 45 working days after receipt, interest shall accrue at a rate of fifteen percent (15%) beginning with the first calendar day after the 45 working day period. If the Plan fails to pay interest automatically with the claim payment, the Plan is required to pay a $10 fee.

Section 1371.35 applies to claims for emergency services. If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 45 working days after receipt, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of fifteen percent (15%) per annum beginning with the first calendar day after the 45 working day period

Our examination disclosed that the Plan failed to pay claims within the timeframes required by Sections 1371 and 1371.35. The Plan also failed to calculate and pay interest on payments made after the statutory 45 working day requirement.

The following categories summarize the type of deficiencies wherein claims or portions of claims were not paid or denied within the statutory requirement:

a. Claims paid to noncontracting providers were paid at an amount lower than billed charges without adequate documentation to support payment.

b. Our examination disclosed that 4,874 claims out of 223,214 (or 2.2%) paid during the period July 1, 2000 through August 31, 2001 were paid beyond the 45 working day timeframe.

c. Claims were paid beyond the 45 working day timeframe and were NOT paid interest in accordance with Section 1371.

d. Claims were paid beyond the 45 working day timeframe and were NOT paid interest or the $10 fee in accordance with Section 1371.

e. Emergency claims were paid beyond the 45 working day timeframe and were NOT paid interest based on the greatest of $15 or 15% in accordance with Section 1371.35.

f. Our examination disclosed that 4,773 claims out of 96,141 (or 5%) denied claims during the period July 1, 2000 through August 31, 2001 were denied beyond the 45 working day timeframe.

The Preliminary Report required the Plan to submit a corrective action plan that describes the steps taken to ensure compliance with the reimbursement and denial requirements of Section 1371 and 1371.35. The corrective action plan was to specifically address each of the areas noted above. The Plan was also to provide a copy of their policies and procedures in regards to the corrective action with its response to this report.

In addition, the Plan was required to state the date these procedures were implemented and identify the management position responsible for ensuring compliance with the above Sections, as well as a description of the controls implemented for continued compliance.

The Plan responded that the Department's sample selection was not statistically valid as difficult and unclean claims were chosen making many of the claim samples biased.

The Plan provided the following responses in regards to the Department's lettered paragraphs presented above:

a. For non-contracted providers, the Plan does pay claims at a usual and customary rate for commercial members. If the provider bills the member for the balance, we will pay the claim in full. If the member is a Medi-Cal Beneficiary, claims for non-contracted providers are paid per Title 19 at Medi-Cal rates.

b. Based on this statement the plan paid 97.98% of claims in the required time frame. The required claims compliance standard is for clean claims and the claims data provided to DMHC contained both clean and non-clean claims; thus the percentage of compliance would be higher if the non-clean claims were not included in the score. The Plan will continue to work towards 100% of claims paid timely.

c. We are 95% compliant in paying interest to providers when claims are not paid within the 45 working days. An in-service was conducted April 22, 2002 to

reinforce to claim adjusters and claims auditors the necessity to pay interest on claims that processed beyond the 45 working days. Auditors were instructed to monitor interest payments on adjudicated claims and to notify the adjuster and their supervisor if a claim was processed untimely without paying interest.

d. If interest is not paid at the time of processing on an untimely claim a $10.00 fee must be paid to the provider. This was included in the in-service described in "c" above.

e. An interest payment of 15% or $15 dollars for emergency claims was included in the in-service described in "c" above.

f. Approximately 95% of claims were denied within the appropriate time frame. Review and determination of the cause for untimely processing of denied claims will continue to be reviewed to ensure corrective action and improvement continue to be achieved. Compliance in this area will be reported to the Plan's Administrative Quality Improvement Committee (ASQIC). A report will be presented to this committee monthly beginning May 2002. The report will demonstrate the Plan's level of compliance as stated in Sections 1371 and 1371.35.

The Plan also stated that steps were taken to correct the deficiencies as described above. The Plan included a copy of its Policies & Procedures for the areas above and the completed corrective action for interest payment at the time of claims processing. The Claims Director is responsible for the implementation and compliance of the areas.

The Department finds that the compliance effort, as set forth above, is not fully responsive to the deficiency cited and the corrective action required by the Department.

The Plan's response to paragraph "a" above indicates that the Plan pays usual and customary instead of billed charges to non-contracting providers and will pay the claim in full "if" the provider bills the enrollee.

The plan is again directed to pay claims from non-contracted providers at billed charges unless an arrangement is documented between the Plan and the non-contracting provider to allow for a discounted payment. This will ensure that the provider does not balance bill the enrollee.

The Plan is required to state the action taken to ensure that non-contracting providers are paid at billed charges in compliance with Rule 1300.67(g), Section 1371.4 (c) and Section 1379(b).

REPEAT DEFICIENCY

The Plan's failure to comply with Section 1371 was also reported in our Confidential Report of Examination Findings dated June 20, 1997, following our prior examination for the period ended September 30, 1996. The Plan's response received on July 22,1997 set

forth corrective action taken to ensure compliance with Section 1371 and the proper payment of interest. In addition, this was also a repeat deficiency from our Confidential Report of November 24, 1992.

The Preliminary Report required the Plan to explain why the corrective action implemented did not ensure continued compliance and to state the measures taken to prevent further recurrence of noncompliance in this area.

The Plan responded that it did not score below 95% in 3 of the 5 timeliness requirements noted above, which demonstrates compliance and improvement. For requirement "d" the Plan scored 89% and for requirement "e" the Plan scored 85%, which demonstrates a strong commitment to continued improvement. In-service training will be conducted once a month to re-enforce regulatory guidelines for the Plan's adjusters.

The past Corrective Action Plan did show great improvement and the majority of late payments included interest. With the implementation of the above Corrective Action Plan, the Plan will be compliant in all areas above.

The Department finds that the Plan's corrective action set forth above is responsive to the corrective action cited by the Department.

3. STATUS OF CLAIMS

Rule 1300.77.4 states that every plan shall institute procedures whereby all claim forms received by the plan from providers of health care services for reimbursement are maintained and accounted for in a manner which permits the determination of date of receipt of any claim, the status of any claim, and the dollar amount of unpaid claims at any time and the rapid retrieval of any claim. Rule 1300.77.4 also states that these procedures shall involve the use of either a claims log, claims numbering system, electronic data processing records, and/or any other method held unobjectionable by the Director.

Our examination disclosed the following deficiencies:

a. the claim payable balance presented in the financial statements does not include claims received but not yet processed.

b. the date of receipt and/or date of service for 19 out of 85 paid and denied claims tested were not input correctly.

c. that 7 out of 85 paid claims requested for review were not provided.

The Preliminary Report required the Plan to describe the procedures implemented to demonstrate compliance with Rule 1300.77.4. These procedures should specifically address the deficiencies noted above. The Plan is also required to state the date these procedures were implemented, the controls implemented for ongoing monitoring, and identify the management

position that has the responsibility for implementing these procedures and ensuring ongoing compliance with this Rule.

The Plan provided the following responses in regards to the Department's lettered paragraphs presented above:

a. *The Plan implemented a process to quantify the claims received but not yet entered into the claims system. The Plan will estimate the total claims liability by multiplying the product of the claims count by a historical average claim adjudication amount. The product of this computation will be included in claims payable.*

b. *Many errors noted by Department as input errors were due to reversed claims. When a claim is re-worked many times it is reversed, and the original received date remains in the system. This will increase the number of days for processing when actually the claim was previously processed. Most of these claims are not clean claims and do not fall in the 45 working day requirement.*

c. *There are types of claims that a hard copy image is not available. These types of claims are electronically filed, CHDP claims where all copies are sent out to providers or agencies and also placed in the member's chart; and, Providers submitting claims on a list and not standard HCFA form. The majority of the claims not provided for review fell into one of the categories above.*

The Plan further stated that based on the explanations above, the input errors were actually reprocessed claims and the claims not available for review were due to legitimate reporting requirements and due to EDI submission. The Plan will make every effort through auditing and reporting to ensure that data entry by staff is accurate and that claims are available for review to the Department when requested. The Claims Director is responsible for the implementation and ongoing compliance with the rule.

The Department finds that the Plan's corrective action set forth above is responsive to the corrective action cited by the Department.

However, the Plan did not state the date on which it implemented the process to quantify the claims received, but not yet processed, for presentation of its claims payable liability.

The Plan is again required to state the date it implemented this process.

D. FIDELITY BOND-*Repeat Deficiency*

Rule 1300.76.3(a) requires that each plan shall at all times maintain a fidelity bond covering each officer, director, trustee, partner and employee of the plan, whether or not they are compensated. Furthermore, it shall provide for thirty (30) days' notice to the Director prior to cancellation.

The fidelity bond presented for our review did not include an endorsement stating that the bond covers each officer, director, trustee, partner and employee of the plan, whether or not

they are compensated; nor did it provide for thirty (30) days' notice to the Director prior to cancellation.

The Preliminary Report required the Plan to submit a copy of a fidelity bond that demonstrates compliance with the above requirements. The Plan was also required to identify the management position that has the responsibility for ensuring compliance with this Rule and provide a description of the controls implemented for ongoing monitoring.

The Plan stated it is amending it's fidelity bond insurance to include an endorsement stating the policy covers each officer, director, trustee, partner and employee of the Plan, whether or not they are compensated. A copy of a letter from the Plan's insurance broker was included in the Plan's response. The Plan stated that its CFO is responsible for ensuring compliance with the rule and will personally review the document when renewed for compliance.

The Department finds that the Plan's corrective action set forth above is not fully responsive to the corrective action cited by the Department.

The Plan is again required to file a copy of the fidelity bond that demonstrates compliance with <u>both</u> required endorsements. The Plan's response did not address the cancellation endorsement.

REPEAT DEFICIENCY

The Plan's failure to comply with the cancellation requirement of Rule 1300.76.3(a) was also reported in our Confidential Report of Examination Findings dated June 20, 1997, following our prior examination for the period ended September 30, 1996. The Plan's response received on July 22,1997 set forth a copy of the corrected fidelity bond.

The Preliminary Report required the Plan to explain why the corrective action implemented did not ensure continued compliance and to state the measures taken to prevent further recurrence of noncompliance in this area.

The Plan stated that it changed insurance carriers and risk management personnel responsible for procuring fidelity bond insurance. The Chief Financial Officer will ensure that the risk manager is apprised of statutory requirements applicable to insurance arrangements.

The Department finds that the Plan's corrective action set forth above is responsive to the corrective action cited by the Department.

E. RESTRICTED DEPOSITS

Section 1376.1 and Rule 1300.76.1 requires each plan licensed pursuant to the provision of the Act to deposit with the Director or at the discretion of the Director with any bank authorized to do business in this state and insured by the Federal Deposit Insurance Corporation, an amount which at all times shall have a value of not less than $300,000.

Section 1374.68(a) requires each plan that offers a point of service contract to maintain a deposit with the Director in an amount that is the greater of $200,000 or 120% of the plan's current monthly claims payable plus incurred but not reported balance for out-of-network coverage or services provided under point of service contracts.

Our examination disclosed that both deposits were withdrawn from the bank on June 28, 2001 and a substitute deposit was made on July 5, 2001 without approval of the Department. Both deposits were combined and placed into one Treasury Bill account for the amount of $500,000. In addition, proper assignment forms were not provided by the Plan.

The Preliminary Report required the Plan to submit, with its response to this report, the original and one copy of each assignment form to support the separate deposits required under the above Section and Rule. The Plan was also required to provide evidence that these deposits are in separate bank accounts.

Furthermore, the Preliminary Report required the Plan to submit a copy of its policies and procedures implemented to ensure that compliance is maintained with Rule 1300.76.1 and Section 1374.68 at all times. The Plan was also required to provide the date these procedures were implemented, the management position responsible for oversight of these procedures and ensuring continued compliance in this area.

The Plan responded that it maintained a deposit, pursuant to the above Section and Rule, in the amounts of $300,000 and $200,000, respectively in a combined deposit with its bank. The Plan provided the Department with the original and one copy of separate assignment forms supporting each deposit in its response. The Plan's Chief Financial Officer will ensure that an assignment form will be completed and provided to the Department upon maturity of any short-term investments.

The Department finds that the Plan's corrective action set forth above is not fully responsive to the corrective action cited by the Department.

The Plan is again required to submit a copy of its policies and procedures implemented to ensure compliance with the above Section and Rule.

In addition, the Plan's response to paragraph 9 of Section IV. A of this report and its response above states that the Plan's Chief Financial Officer will "ensure that an assignment form is completed and provided to the Department upon maturity" of any restricted deposit investments. This response appears to indicate that the Plan does not understand the requirements of Rule 1300.76.1(f), which states that a deposit may be withdrawn after making a substitute deposit and that this substitute deposit be approved by the Department before being deposited or substituted.

The Plan is required to confirm that it understands the requirements of Rule 1300.76.1 and that prior approval from the Department is required.

F. FINANCIAL STATEMENT PRESENTATION

Rule 1300.84.2 sets forth the requirements for the filing of quarterly financial statements with the Department. The rule states that the quarterly financial statements (which need not be certified) are to be prepared in accordance with generally accepted accounting principles and on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c), unless the plan receives the written approval of the Director to vary from that basis and the variance is adequately noted in its report under this section. This rule also refers to Rule 1300.84.06(b) that sets forth the requirements for the supplemental information that is to accompany the Orange Blank filings.

Our examination noted the following concerns with the Orange Blank and supplemental information for the fiscal year ended June 30, 2001:

1. The Plan did not properly complete the cover page. All information lines need to be completed. The Directors need to be disclosed. The affidavit is to be properly completed in addition to being executed by the President, Secretary and Treasurer.

2. Footnote disclosure was not provided as an attachment to the Orange Blank.

3. An explanation of the method of calculating the provision for incurred but not reported claims as required in supplemental information item 1 was not attached to the Orange Blank as disclosed in item 1.

4. The Plan has transactions with affiliates that may result in accounts receivable and/or donated disclosed a receivable of $45,158 due from Universal Care of Tennessee at June 30, 2001 that was not disclosed in item 2.

5. Reclassification entries, as noted in Section I of this report, were needed to properly present certain financial information on the proper line item of the Orange Blank at June 30, 2001.

6. As discussed in Section III. of this report, the required TNE was not properly calculated due to supplemental information for calculating the required TNE not being completed.

7. As discussed in Section IV. C. 3. of this report, the Plan has not included claims received but not entered into the system within the Claims Payable balance reported on Report 1 – Part B, Line 2 of the Orange Blank.

8. Schedules and work papers are not maintained by the Plan to support the information presented in the supplemental information, Point of Service supplemental information and the required calculation of TNE as filed with the Department. As a result, the documentation provided during our examination differed from the filed information as the Plan reported estimated amounts instead of actual.

The Preliminary Report required the Plan to provide the corrective action taken to ensure that compliance with the above concerns is demonstrated in the quarterly financial statement for March 31, 2002 due to be filed on May 15, 2002. The Plan is also to provide the policies and procedures implemented to ensure compliance. Furthermore, the Plan is required to state the date these policies and procedures were implemented, the management position responsible for compliance and the controls implemented for monitoring continued compliance.

The Plan provided the following responses in regards to the Department's numbered paragraphs above:

1. *The Plan's Chief Financial Officer will ensure that the cover page is completed in its entirety.*

2. *The Plan's Chief Financial Officer will ensure that footnote disclosures are included with the statutory filing as required.*

3. *The Plan's Chief Financial Officer will ensure that the Plan's IBNR Policy and Procedures is included with the statutory filings.*

4. *The Plan's Chief Financial Officer will ensure that affiliate transactions are disclosed in the statutory filings.*

5. *The Plan's Chief Financial Officer will review the statutory filing to ensure proper classification of amounts presented.*

6. *As previously stated, the Plan calculated TNE using its interpretation of Method C.*

7. *As previously noted, the Plan developed a method to quantify claims received, but not entered into the system and report the amount in the statutory filing.*

8. *Certain reported amounts were updated for current information. The Plan agrees to maintain documentation supporting supplemental amounts included in the statutory filings.*

The Plan provided with its response its Policy & Procedure developed to ensure appropriate documentation is included in the statutory filings with the Department. The Policy & Procedure includes an assignment checklist of supplemental information included in the statutory filing to ensure responsible parties provide such data timely. The Plan stated that it would maintain supporting documentation on file. The Plan also stated that effective with the March 31, 2002 quarterly statutory filing, the Plan's Chief Financial Officer would review statutory filings prior to submission to the Department to ensure that each item is completed in its entirety.

The Department finds that the Plan's corrective action set forth above is responsive to the corrective action cited by the Department.

However, the Department finds that the corrective action taken by the Plan does not appear to have been fully implemented for the quarterly filing for March 31, 2002 or for

the quarterly filing for June 30, 2002, as the Supplemental Information submitted with these filings was not completed for explanation of method used to calculate IBNR, disclosure of affiliate receivables or donated services. In addition, as presented in Section IV. C.1 of the March 31, 2002 quarterly report, Schedule I-Analysis of Total Medical Liability to Actual Claims Paid was not completed for paid claims data.

The Plan is again required to state the corrective action taken and the management position responsible to ensure that the Plan properly completes the financial statement and supplemental information in compliance with the above Rules.

G. MONITORING FINANCIAL VIABILITY OF CAPTIATED PROVIDERS-*Repeat Deficiency*

Rule 1300.67.8(c) requires a health plan to monitor the financial capacity of providers when they are compensated on a capitated basis. Section 1375.1(a)(3) and (b) requires a health plan to demonstrate a procedure for prompt payment or denial of provider claims and the financial soundness of the Plan's arrangements for health care services. Health plans that capitate provider groups and delegate claims payment functions to these provider groups must have procedures in place to ensure that these groups comply with Sections 1371, 1371.35 and 1375.1(a)(3) and (b).

Our examination disclosed that the Plan has not updated its policy and procedures to obtain financial statements on a quarterly basis as stated in its provider contracts. Our examination disclosed that the Plan did not adequately document the performance of its monitoring procedures and its evaluation of the financial statements of the providers.

The Preliminary Report required the Plan to state the corrective action taken, provide a copy of any updated policies and procedures and state the management position responsible for ensuring the implementation of these corrective actions, and the controls implemented for monitoring continued compliance in this area.

The Plan responded that it's audit worksheets are prepared by a financial analyst and reviewed by the Chief Financial Officer and will be initialed by the him in the future to provide evidence of this review.

The Plan stated that that a financial analyst will perform on-site audits. The Plan's Chief Financial Officer will ensure that it continues to conduct follow-up examinations. The Plan stated that its monitoring schedules for obtaining financial information are updated on a quarterly basis. The Plan acknowledges that certain providers have offered resistance in issuing its financial statements. The Plan agrees to continue to put forth its best efforts to obtain financial statements from its capitated providers. The Plan's Chief Financial Officer will monitor this process.

A copy of the Plan's Policy and Procedures were provided in its response. The Plan stated it has significantly improved its provider financial viability monitoring process. While it is the Plan's objective to control administrative costs, the Plan will allocate

additional resources to further improve it's over site efforts, including but not limited to, on site financial reviews.

The Department finds that the Plan's corrective action set forth above is responsive to the corrective action cited by the Department.

However, the Department notes that the Policy and Procedures provided does not address the action taken by the Plan to monitor a capitated provider group's compliance with Section 1371 and 1371.35.

The Plan is required to provide a revised Policy and Procedures to include the Plan's monitoring for compliance with these Sections.

REPEAT DEFICIENCY

A similar deficiency was also reported in our Confidential Report of Examination Findings dated June 20, 1997, following our prior examination for the period ended September 30, 1996. The Plan's response received on July 22,1997 assured the Department that this issue was resolved. In addition, this was also a repeat deficiency from our Confidential Report of November 24, 1992.

The Preliminary Report required the Plan to explain why the corrective action implemented did not ensure continued compliance and to state the measures taken to prevent further recurrence of noncompliance in this area.

The Plan responded that it believes it has substantially improved its contracted provider financial viability over site process. The Plan's financial viability oversight efforts have resulted in timely transfer of enrollees prior to provider bankruptcy, de-delegation of providers from claims payment, financial risk, and implementation of direct PCP contract arrangements to ensure continuity of care without member disruption or impairment of provider relationships. The Plan will continue to allocate additional resources to further improve it's over site efforts, including but not limited to, on site financial reviews.

The Department finds that the Plan's corrective action set forth above is responsive to the corrective action cited by the Department.

NONROUTINE EXAMINATION

The Plan is advised that the Department will conduct a nonroutine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this Report. The cost of such examination will be charged to the Plan in accordance with Section 1382(b).

No response required to this Section.

September 24, 2002

Ms. Joan Larsen
Supervising Examiner
Department of Managed Health Care
Office of Health Plan Oversight
Division of Financial Oversight
320 West 4th Street, Suite 880
Los Angeles, CA 90013-2344

RE: ROUTINE EXAMINATION OF UNIVERSAL CARE

Dear Ms. Larsen:

The following information is provided as an appendage to the Final Report of the routine examination of Universal Care for the fiscal year ended June 30, 2001. This information is meant to accurately inform our members, providers, vendors, customers, other business partners and the general public of our position on the report.

At Universal Care, we are proud of our heritage of providing access to quality health care to hundreds of thousands of Californians since 1983. We strive to work with all regulatory agencies, including the Department of Managed Health Care, to ensure that we protect the health of our members and operate responsibly.

However, we respectfully disagree with a number of the assertions made in the preceding Final Report by the Department, particularly those regarding the Tangible Net Equity (TNE) violation of June 2001 that was referred to the agency's Office of Enforcement. We also contest other assertions, and the Department's appraisal that we have not demonstrated adequate financial viability.

First, it should be noted that Universal Care is currently in full compliance with the Department's TNE requirement. In fact, due to robust growth in fiscal year 2002, our TNE has increased in just one year by 36 percent. In addition, we are also financially viable, experiencing dramatic growth resulting in ample and healthy cash and cash equivalents. During fiscal year 2002, our cash and cash equivalents increased 129 percent, from $8.8 million as of June 30, 2001, to $20.1 million as of June 30, 2002.

To ensure future growth and profitability, we have increased commercial premiums by 25 percent during fiscal year 2002, terminated certain unprofitable employer group contracts, and restructured select provider contract arrangements resulting in profitability while continuing to experience enrollment growth. We are proud to operate a three-year "commendable" NCQA

accredited commercial health plan and continue to experience solid growth and rising member satisfaction.

Following are specific responses to issues in the Final Report with which we do not agree:

Tangible Net Equity (TNE)

It was our own employees at Universal Care, and not auditors at the Department, who first identified information that resulted in the TNE deficiency, and we immediately took action to correct the situation. The information we identified had to do with an increase in the claims liability, which was recorded in our annual audit report for the fiscal year ended June 30, 2001. During the Department's examination, subsequent to the issuance of the annual audit report, it became apparent from additional information that the claims liability required an additional increase. The Department reacted to the additional information in two main areas with which we disagree:

1. The Department requested that we revise our audited financial statements for the year ended June 30, 2001 based upon the new information we identified.

2. The Department determined a June 24, 2002 effective date for the plan's subordination agreement which, if accepted, significantly delayed Universal Care's return to compliance with its TNE requirements.

To support the first point, we have attached a letter from Ernst & Young (Attachment A) giving guidance that does not support the Department's request to restate financial statements using information that became available only after the audit report was completed. Their independent audit concluded that the information should be reported in fiscal 2002 earnings and not in 2001. This finding is in agreement with Generally Accepted Accounting Principles as promulgated in accordance with Accounting Principal Board No. 20 ("APB No. 20").

As for the second point, Universal Care takes issue with the time period for which the Department has determined the Plan to be out of compliance with its TNE requirements. In the last quarter of 2001, Universal Care executed subordination agreements and filed them with the Department and promptly responded to the Department's requests for additional information regarding such agreements. Universal Care utilized a form subordination agreement provided by the Department and submitted its filings as Amendments to its plan license application as required by the Knox-Keene Act. We believe that the Plan's subordination agreements should be applied towards the Plan's TNE calculation as of the effective date of the subordination agreements and not the later date determined by the Department.

Financial Viability

We take seriously the requirement that Universal Care demonstrate a fiscally sound operation. We are pleased to report that Universal Care's financial projections have been achieved for the period July 1, 2001 through the current period as of July 1, 2002, as corroborated by the Department's own supervising examiner's review of supporting documentation during the examination. A copy of our operating projections for the fiscal year ending June 30, 2003 is included as Attachment B to this letter.

In conducting its audit, the Department hired a contractor that we believe failed to audit the financial statement projections provided. We have made numerous requests to the Department to review the contractor's work papers and documentation supporting their audit conclusion. While Department management agreed to provide the work papers, to date they have not done so. Without such documentation, we find it hard to appropriately respond to the Department's comments concerning the contractor's conclusions, which are inconsistent with our operating results and financial projection.

Furthermore, we refute that we have lines of business that are not profitable. Copies of our consolidated projected operating results, including those of our commercial and Seriously and Persistently Mentally Ill (SPMI) program operating results for fiscal year 2003, which demonstrate profitability, are included as Attachments B, C and D, respectively. Because we do not have any contracts that are not profitable, none can be classified as subject to the provisions of FASB Statement No. 5, Accounting for Contingencies or "Loss Contracts" or paragraphs 13.05 and 13.06 of the AICPA Audit and Accounting Guide for Health Care Organizations.

Financial Statement Presentation

We believe the $1.3 million classified as a long-term liability in the January 31, 2002 through June 30, 2002 financial reports is appropriate, as opposed to the Department's assertion that it be classified as a current liability. Generally Accepted Accounting Principles ("GAAP") defines current liabilities to include: (1) all obligations for which payment will require the use of existing current assets (2) obligations that will probably be paid from current assets within one year. The claims covering the $1.3 million do not meet either of these tests, as they have service dates in excess of one year prior to the report date. Universal Care's independent accounting firm has reviewed this issue and concurs with our position.

Claims Liability

To meet the Department's requirement that we accurately estimate incurred and unreported claims, we have made appropriate changes in our methodology of calculating claims liability, which includes a hindsight analysis review. Although not required by regulation, Universal Care is now utilizing an Independent Certified Actuary to review its claims liability

calculation on a semi-annual basis, which we believe will ensure that claims liability is fairly stated.

Conclusion

Universal Care's executive management team has extensive experience in operating health care service plans in California. Over the past 19 years, Universal Care has developed a thorough understanding of the laws and regulations governing its operations and a commitment to excellence in service. As the result of information provided by the Department through its financial examination, Universal Care has developed management initiatives and policies and procedures to address the legitimate areas of concern raised by the Department and to further enhance Universal Care's ongoing viability. Universal Care looks forward to continue working diligently with the Department to ensure that we are operating at optimum efficiency and meeting all the prescribed rules designed to protect and promote the health care of Californians.

Sincerely,
Jeffrey V. Davis
Chief Operating Officer

[Attachment A referenced in the above letter may be obtained in hardcopy by contacting Eriberto Salmo, Office Technician, at the Department of Managed Health Care at 213-576-7636]

Attachment B
UNIVERSAL CARE
SPMI PROGRAM
FISCAL YEAR 2003

ENROLLMENT	**Jul-02**	**Aug-02**	**Sep-02**	**Oct-02**	**Nov-02**	**Dec-02**	**Jan-03**	**Feb-03**	**Mar-03**	**Apr-03**	**May-03**	**Jun-03**
CMS	274	280	284	289	294	299	304	309	314	319	324	329
CalOPTIMA	37	37	37	37	37	37	37	37	37	37	37	37
Total Enrollment	311	317	321	326	331	336	341	346	351	356	361	366
REVENUE												
CMS	164,674	168,280	170,684	173,689	176,694	179,699	193,958	197,148	200,338	203,528	206,718	209,909
CALOPTIMA	22,237	22,237	22,237	22,237	22,237	22,237	22,237	22,237	22,237	22,237	22,237	22,237
Co-payments	2,022	2,061	2,087	2,119	2,152	2,184	2,217	2,249	2,282	2,314	2,347	2,379
Total Revenue	$188,933	192,578	195,008	198,045	201,083	204,120	218,412	221,634	224,857	228,079	231,302	234,525
MEDICAL SERVICES												
Inpatient Services	101,075	91,404	93,122	95,183	97,260	99,354	101,464	103,591	105,735	107,896	110,075	112,270
Specialist Services	1,555	1,409	1,439	1,474	1,510	1,546	1,582	1,619	1,656	1,693	1,731	1,770
Pharmacy	19,904	18,293	18,941	19,676	20,434	21,214	6,080	6,309	6,544	6,787	7,037	7,295
Medical Staff	30,688	30,688	30,688	30,688	30,688	30,688	30,688	30,688	30,688	30,688	30,688	30,688
Occupancy	2,892	2,604	2,641	2,688	2,734	2,781	2,827	2,874	2,920	2,967	3,013	3,060
Total Medical Services	156,114	144,399	146,832	149,709	152,626	155,582	142,641	145,080	147,544	150,032	152,544	155,082
Med Loss	83%	75%	75%	76%	76%	76%	65%	65%	66%	66%	66%	66%
Administration	18,893	19,258	19,501	19,805	20,108	20,412	21,841	22,163	22,486	22,808	23,130	23,452
Profit	$ 13,925	$28,921	$28,675	$28,532	$28,349	$28,126	$53,929	$54,390	$54,827	$55,240	$55,627	$55,990

UNIVERSAL CARE

COMMERCIAL LINE OF BUSINESS

OPERATING PROJECTIONS

FISCAL YEAR 2003	**TOTAL**	**July-02**	**August-02**	**September-02**	**October-02**	**November-02**	**December-02**	**January-03**	**February-03**	**March-03**	**April-03**	**May-03**	**June-03**
COMMERCIAL ENROLLMENT		132,152	129,373	125,799	116,726	121,880	122,480	104,508	104,908	105,308	105,708	106,108	106,508
CULINARY ENROLLMENT		5,900	5,900	5,900	5,900	5,900	5,900	5,900	5,900	5,900	5,900	5,900	5,900
REVENUE:													
PREMIUM BILLING	200,528,496	17,712,333	17,599,903	17,294,847	16,250,594	17,198,487	17,542,810	15,679,335	15,905,102	16,070,001	16,274,804	16,428,702	16,571,580
PREMIUM-CULINARY	7,818,444	651,537	651,537	651,537	651,537	651,537	651,537	651,537	651,537	651,537	651,537	651,537	651,537
VISION-COMMERCIAL	7,411	709	694	675	626	654	657	561	563	565	567	569	571
FEE-FOR-SERVICE (STAFF MODEL)	790,657	75,635	74,045	71,999	66,806	69,756	70,100	59,814	60,043	60,271	60,500	60,729	60,958
CO-PAYMENTS	483,510	46,253	45,281	44,030	40,854	42,658	42,868	36,578	36,718	36,858	36,998	37,138	37,278
INTEREST	169,057	16,172	15,832	15,395	14,284	14,915	14,989	12,789	12,838	12,887	12,936	12,985	13,034
OTHER INCOME	95,066	9,094	8,903	8,657	8,033	8,387	8,429	7,192	7,219	7,247	7,274	7,302	7,329
TOTAL REVENUE	209,892,641	18,511,733	18,396,194	18,087,139	17,032,734	17,986,394	18,331,389	16,447,805	16,674,019	16,839,366	17,044,616	17,198,962	17,342,288
HOSPITAL EXPENSES:													
INPATIENT CLAIMS-CAPITATED	3,108,281	297,342	291,089	283,048	262,634	274,230	275,580	235,143	236,043	236,943	237,843	238,743	239,643
INPATIENT/SPECIALIST CLAIMS	82,446,389	7,486,699	7,402,556	7,270,036	6,813,157	7,185,129	7,292,706	6,284,843	6,371,987	6,460,245	6,549,632	6,640,160	6,689,240
TOTAL CLAIMS EXPENSE	85,554,670	7,784,041	7,693,645	7,553,084	7,075,790	7,459,359	7,568,286	6,519,986	6,608,030	6,697,188	6,787,475	6,878,903	6,928,883
NON HOSPITAL MEDICAL EXPENSES:													
MEMBER MONTHS													
CAPITATION	57,907,846	5,328,369	5,259,789	5,157,105	4,825,035	5,080,067	5,147,618	4,428,889	4,464,365	4,500,059	4,535,974	4,572,109	4,608,467
PHYSICIAN COMPENSATION-STAFF MODEL	2,835,531	251,554	247,085	241,060	224,419	235,110	237,055	229,072	230,715	232,367	234,027	235,696	237,373
SUPPORT STAFF COMPENSATION	3,260,918	276,540	271,627	265,004	246,710	258,463	260,601	275,357	277,332	279,318	281,313	283,319	285,335
MEDICAL GROUP ADMINISTRATION	2,557,431	225,411	221,406	216,007	201,096	210,676	212,419	207,981	209,473	210,972	212,479	213,994	215,517
VISION (COMMERCIAL)	93,919	8,980	8,792	8,550	7,934	8,285	8,327	7,105	7,133	7,161	7,189	7,217	7,244
DENTAL COSTS	396,768	37,939	37,144	36,121	33,519	35,001	35,177	30,018	30,135	30,252	30,370	30,487	30,605
CLINIC OCCUPANCY	1,598,718	152,869	149,667	145,544	135,058	141,033	141,740	120,952	121,425	121,898	122,371	122,844	123,318
PHARMACY - STAFF MODEL	2,024,686	190,332	186,951	182,392	169,802	177,890	179,362	153,553	154,655	155,762	156,875	157,994	159,118
PHARMACY- NETWORK	22,292,770	1,934,301	1,933,076	1,918,833	1,817,534	1,937,324	1,987,420	1,731,127	1,755,854	1,780,909	1,806,295	1,832,017	1,858,079
REINSURANCE PREMIUMS	1,914,944	183,186	179,334	174,380	161,803	168,947	169,779	144,866	145,421	145,975	146,530	147,084	147,639
LAB, X-RAY(IN HOUSE)	4,037	386	378	368	341	356	358	305	307	308	309	310	311

LAB, X-RAY(OUTSIDE PROVIDERS)	240,021	22,563	22,162	21,622	20,129	21,088	21,263	18,203	18,334	18,465	18,597	18,730	18,863
RADIOLOGY/REHAB	54,661	5,138	5,047	4,924	4,584	4,803	4,842	4,146	4,175	4,205	4,235	4,265	4,296
PATIENT TRANSPORTATION	43,047	4,047	3,975	3,878	3,610	3,782	3,813	3,265	3,288	3,312	3,335	3,359	3,383
TOTAL	95,225,296	8,621,615	8,526,433	8,375,788	7,851,576	8,282,826	8,409,773	7,354,839	7,422,612	7,490,964	7,559,900	7,629,426	7,699,547
TOTAL MEDICAL EXPENSES	180,779,966	16,405,656	16,220,077	15,928,872	14,927,366	15,742,185	15,978,058	13,874,825	14,030,642	14,188,152	14,347,374	14,508,328	14,628,430
MEDICAL LOSS %	86%	89%	88%	88%	88%	88%	87%	84%	84%	84%	84%	84%	84%
ADMINISTRATION EXPENSES:													
ADMINISTRATION	10,837,425	841,352	891,091	869,362	809,350	847,904	854,918	940,920	946,096	951,286	956,491	961,710	966,945
COMMERCIAL MARKETING/COMMISSIONS	11,924,370	1,033,320	1,014,963	990,214	921,859	965,772	973,762	990,409	995,857	1,001,320	1,006,799	1,012,293	1,017,802
UNDERWRITING	479,438	45,157	44,355	43,274	40,286	42,205	42,555	36,431	36,632	36,833	37,034	37,236	37,439
TOTAL ADMINISTRATION & MARKETING	23,241,233	1,919,830	1,950,409	1,902,850	1,771,496	1,855,882	1,871,235	1,967,761	1,978,584	1,989,439	2,000,324	2,011,239	2,022,186
TOTAL EXPENSES	204,021,199	18,325,486	18,170,486	17,831,721	16,698,862	17,598,066	17,849,293	15,842,586	16,009,226	16,177,590	16,347,698	16,519,568	16,650,616
PROFIT BEFORE TAXES	5,871,442	186,247	225,708	255,417	333,872	388,328	482,096	605,220	664,793	661,775	696,919	679,394	691,671
PROVISION FOR INCOME TAXES	(2,524,720)	(80,086)	(97,054)	(109,829)	(143,565)	(166,981)	(207,301)	(260,244)	(285,861)	(284,563)	(299,675)	(292,140)	(297,419)
NET INCOME	3,346,722	106,161	128,653	145,588	190,307	221,347	274,795	344,975	378,932	377,212	397,244	387,255	394,253
PRETAX PERCENTAGE	2.80%	1.01%	1.23%	1.41%	1.96%	2.16%	2.63%	3.68%	3.99%	3.93%	4.09%	3.95%	3.99%
NET INCOME %	1.59%	0.57%	0.70%	0.80%	1.12%	1.23%	1.50%	2.10%	2.27%	2.24%	2.33%	2.25%	2.27%

UNIVERSAL CARE

CONSOLIDATED OPERATIONS

OPERATING PROJECTIONS

FISCAL YEAR 2003

	TOTAL	July-02	August-02	September-02	October-02	November-02	December-02	January-03	February-03	March-03	April-03	May-03	June-03
CULINARY	7,672,441	505,532	651,537	651,537	651,537	651,537	651,537	651,537	651,537	651,537	651,537	651,537	651,537
COMMERCIAL	93,094,101	8,076,713	7,825,262	7,528,507	6,572,640	7,360,502	7,438,750	7,852,440	7,957,764	8,038,918	8,082,191	8,151,652	8,208,763
CALPERS	15,661,829	2,540,064	2,571,386	2,597,588	2,626,149	2,650,931	2,675,713	-	-	-	-	-	-
CALIFORNIA CHOICE	69,691,753	5,412,071	5,464,346	5,497,557	5,446,148	5,580,779	5,815,460	5,839,105	5,941,137	6,044,916	6,150,472	6,216,406	6,283,355
COMM PAC ADVANTAGE	22,118,474	1,683,875	1,739,041	1,670,827	1,606,197	1,606,197	1,612,769	1,987,709	2,005,755	2,023,931	2,042,240	2,060,680	2,079,254
FRESNO	-			-	-	-	-	-	-	-	-	-	-
COMMERCIAL-DENTAL	7,489,656	624,138	624,138	624,138	624,138	624,138	624,138	624,138	624,138	624,138	624,138	624,138	624,138
VISION	204,000	17,000	17,000	17,000	17,000	17,000	17,000	17,000	17,000	17,000	17,000	17,000	17,000
AIM	-												
CULINARY-DENTAL	216,503	18,042	18,042	18,042	18,042	18,042	18,042	18,042	18,042	18,042	18,042	18,042	18,042
PLAN TO PLAN	2,530,576	210,302	210,407	210,512	210,618	210,723	210,828	210,934	211,039	211,145	211,250	211,356	211,462
MEDI-CAL LA	160,162,684	13,045,516	13,374,288	13,374,288	13,374,288	13,374,288	13,374,288	13,374,288	13,374,288	13,374,288	13,374,288	13,374,288	13,374,288
MEDI-CAL CALOPTIMA	16,939,385	1,411,615	1,411,615	1,411,615	1,411,615	1,411,615	1,411,615	1,411,615	1,411,615	1,411,615	1,411,615	1,411,615	1,411,615
MEDI-CAL SAN DIEGO	12,595,627	1,049,636	1,049,636	1,049,636	1,049,636	1,049,636	1,049,636	1,049,636	1,049,636	1,049,636	1,049,636	1,049,636	1,049,636
HEALTHY FAMILIES	20,225,646	1,607,508	1,621,683	1,635,858	1,650,033	1,664,208	1,678,383	1,692,558	1,706,733	1,720,908	1,735,083	1,749,258	1,763,433
HEALTHY FAMILIES-DENTAL	5,953,258	369,776	392,745	415,714	438,683	461,652	484,620	507,589	530,558	553,527	576,496	599,464	622,433
MEDICARE	4,105,296	235,008	235,008	235,008	235,008	235,008	235,008	296,208	357,408	418,608	479,808	541,008	602,208
PHARMACY FFS	1,645,488	137,124	137,124	137,124	137,124	137,124	137,124	137,124	137,124	137,124	137,124	137,124	137,124
CHDP	731,328	60,944	60,944	60,944	60,944	60,944	60,944	60,944	60,944	60,944	60,944	60,944	60,944
CCS	-												
MEDI-CAL DENTAL DHS (LAC)	3,923,929	326,994	326,994	326,994	326,994	326,994	326,994	326,994	326,994	326,994	326,994	326,994	326,994
MEDI-CAL DENTAL FFS (OC)	1,371,240	114,270	114,270	114,270	114,270	114,270	114,270	114,270	114,270	114,270	114,270	114,270	114,270
MENTAL HEALTH	-												
FEE FOR SERVICE/C.O.B.	600,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000

COPAYMENTS	1,800,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000
INTEREST INCOME	720,000	60,000	60,000	60,000	60,000	60,000	60,000	60,000	60,000	60,000	60,000	60,000	60,000
MANAGEMENT FEES	-	-	-	-	-	-	-	-	-	-	-	-	-
OTHER INCOME	240,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000
TOTAL INCOME	449,693,215	37,726,129	38,125,466	37,857,159	36,851,063	37,835,588	38,217,119	36,452,131	36,775,982	37,077,542	37,343,128	37,595,413	37,836,497

EXPENSES :													
PHYSICIAN SERVICES	23,064,574	1,889,294	1,894,303	1,899,174	1,902,732	1,909,909	1,916,012	1,920,098	1,928,843	1,937,657	1,946,539	1,955,493	1,964,518
CLINICAL SUPPORT STAFF	31,251,858	2,401,611	2,412,052	2,580,053	2,594,138	2,608,225	2,622,356	2,636,531	2,650,752	2,665,018	2,679,331	2,693,691	2,708,100
CAPITATION-PHYSICIAN	121,813,329	10,673,647	10,577,868	10,465,607	10,103,181	10,381,028	10,454,039	9,680,858	9,751,432	9,822,582	9,895,209	9,967,497	10,040,382
EMERGENCY ROOM	3,023,023	239,443	241,253	243,079	244,924	246,786	248,666	251,819	254,990	258,181	261,391	264,621	267,871
OCCUPANCY	10,816,384	877,967	882,221	886,475	890,728	894,983	899,237	903,492	907,747	912,000	916,256	920,511	924,768
INPATIENT-STAFF	16,016,753	1,229,464	1,238,597	1,247,824	1,257,146	1,266,564	1,276,079	1,314,891	1,354,532	1,395,018	1,436,363	1,478,582	1,521,692
INPATIENT-CAPITATED	127,988,938	11,217,334	11,149,683	10,934,622	10,403,384	10,979,041	11,097,904	10,163,021	10,246,751	10,331,870	10,418,399	10,506,358	10,540,572
OTHER MEDICAL	65,065,960	5,455,036	5,464,110	5,447,179	5,336,149	5,465,695	5,518,735	5,255,601	5,311,268	5,367,453	5,424,160	5,481,399	5,539,175
TOTAL MEDICAL & HOSP	399,040,819	33,983,796	33,860,087	33,704,014	32,732,382	33,752,231	34,033,029	32,126,310	32,406,315	32,689,777	32,977,648	33,268,152	33,507,078
MED LOSS:		90%	89%	89%	89%	89%	89%	88%	88%	88%	88%	88%	89%
ADMINISTRATION													
COMPENSATION	12,339,024	969,703	975,727	1,011,773	1,017,841	1,023,932	1,030,045	1,036,182	1,042,343	1,048,529	1,054,739	1,060,974	1,067,235
OCCUPANCY	12,069,691	973,898	977,730	994,562	998,394	1,002,226	1,006,058	1,009,890	1,013,722	1,017,554	1,021,386	1,025,218	1,029,050
MARKETING	15,502,044	1,279,051	1,275,020	1,264,606	1,229,027	1,261,257	1,272,986	1,301,469	1,309,998	1,317,769	1,324,318	1,330,414	1,336,129
TOTAL ADMINISTRATION	39,910,759	3,222,652	3,228,478	3,270,942	3,245,262	3,287,415	3,309,090	3,347,542	3,366,064	3,383,852	3,400,443	3,416,606	3,432,414
TOTAL EXPENSES	438,951,578	37,206,448	37,088,565	36,974,956	35,977,644	37,039,647	37,342,118	35,473,852	35,772,379	36,073,629	36,378,091	36,684,758	36,939,492
ADMIN %:	9%	9%	8%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%
INCOME (LOSS)	10,741,637	519,680	1,036,901	882,204	873,419	795,941	875,000	978,279	1,003,603	1,003,912	965,037	910,656	897,004
PROFIT SHARE PLAN													
NET INCOME PRETAX	10,741,637	519,680	1,036,901	882,204	873,419	795,941	875,000	978,279	1,003,603	1,003,912	965,037	910,656	897,004
TAXES	4,296,655	207,872	414,761	352,881	349,367	318,376	350,000	391,312	401,441	401,565	386,015	364,262	358,802
NET INCOME	6,444,982	311,808	622,141	529,322	524,051	477,565	525,000	586,967	602,162	602,347	579,022	546,393	538,203
PRETAX PERCENTAGE	2.4%	1.4%	2.7%	2.3%	2.4%	2.1%	2.3%	2.7%	2.7%	2.7%	2.6%	2.4%	2.4%
NET INCOME %	1.4%	0.8%	1.6%	1.4%	1.4%	1.3%	1.4%	1.6%	1.6%	1.6%	1.6%	1.5%	1.4%

UNIVERSAL CARE

BALANCE SHEET

July-02

FISCAL YEAR 2003		**August-02**	**September-02**	**October-02**	**November-02**	**December-02**	**January-03**	**February-03**	**March-03**	**April-03**	**May-03**	**June-03**
CASH & EQUIVALENTS	17,717,870	18,847,188	18,991,208	18,520,355	19,540,606	20,121,240	18,751,082	19,410,220	20,064,613	20,682,286	21,250,584	21,802,748
SHORT TERM INVESTMENTS	322,248	322,248	322,248	322,248	322,248	322,248	322,248	322,248	322,248	322,248	322,248	322,248
ACCOUNTS RECEIVABLE	26,933,153	26,968,153	27,013,153	27,068,153	27,133,153	27,208,153	27,293,153	27,388,153	27,493,153	27,608,153	27,733,153	27,868,153
OTHER RECEIVABLES	7,911,330	7,901,330	7,891,330	7,881,330	7,871,330	7,861,330	7,851,330	7,841,330	7,831,330	7,821,330	7,811,330	7,801,330
INVENTORY	1,890,533	1,890,533	1,890,533	1,890,533	1,890,533	1,890,533	1,890,533	1,890,533	1,890,533	1,890,533	1,890,533	1,890,533
PREPAID EXPENSES	1,788,202	1,788,202	1,788,202	1,788,202	1,788,202	1,788,202	1,788,202	1,788,202	1,788,202	1,788,202	1,788,202	1,788,202
TOTAL CURRENT ASSETS	56,563,336	57,717,654	57,896,674	57,470,821	58,546,072	59,191,706	57,896,548	58,640,686	59,390,079	60,112,752	60,796,050	61,473,214
FURN, FIXT, EQUIP, & LHI	38,709,948	38,934,948	39,159,948	39,384,948	39,609,948	39,834,948	40,059,948	40,284,948	40,509,948	40,734,948	40,959,948	41,184,948
ACCUMULATED DEPRECIATION	(17,462,181)	(17,603,585)	(17,744,991)	(17,886,399)	(18,027,809)	(18,169,222)	(18,310,638)	(18,452,056)	(18,593,476)	(18,734,898)	(18,876,321)	(19,017,748)
NET FIXED ASSETS	21,247,767	21,331,363	21,414,957	21,498,549	21,582,139	21,665,726	21,749,310	21,832,892	21,916,472	22,000,050	22,083,627	22,167,200
OTHER ASSETS-INVESTMENTS	5,219,365	5,194,365	5,169,365	5,144,365	5,119,365	5,094,365	5,069,365	5,044,365	5,019,365	4,994,365	4,969,365	4,944,365
TOTAL ASSETS	83,030,468	84,243,382	84,480,997	84,113,735	85,247,576	85,951,796	84,715,223	85,517,943	86,325,916	87,107,167	87,849,042	88,584,779
LIABILITIES												
ACCOUNTS PAYABLE	13,616,372	13,915,343	14,180,899	14,444,557	14,691,480	14,955,480	15,241,789	15,533,567	15,825,412	16,108,860	16,380,562	16,649,315
CLAIMS LIABILITY-CURRENT	37,100,000	37,587,345	37,220,623	36,251,194	36,841,089	36,931,851	34,992,544	35,066,866	35,141,188	35,215,511	35,289,834	35,364,156
OTHER MEDICAL LIABILITIES	3,252,213	3,322,213	3,397,213	3,477,213	3,562,213	3,652,213	3,747,213	3,847,213	3,952,213	4,062,213	4,177,213	4,297,213
LOANS/NOTES PAYABLE	113,440	147,898	182,356	216,814	251,272	285,730	320,188	354,646	389,104	423,562	458,020	492,478
DEFERRED INCOME	4,460,789	4,460,789	4,460,789	4,460,789	4,460,789	4,460,789	4,460,789	4,460,789	4,460,789	4,460,789	4,460,789	4,460,789
TOTAL CURRENT LIABILITIES	58,542,814	59,433,587	59,441,880	58,850,567	59,806,843	60,286,063	58,762,523	59,263,081	59,768,706	60,270,935	60,766,417	61,263,951
LOANS/NOTES PAYABLE	12,836,350	12,536,350	12,236,350	11,936,350	11,636,350	11,336,350	11,036,350	10,736,350	10,436,350	10,136,350	9,836,350	9,536,350
CLAIMS LIABILITY-LONG TERM	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000	1,600,000
OTHER LIABILITIES	2,657,960	2,657,960	2,657,960	2,657,960	2,657,960	2,657,960	2,657,960	2,657,960	2,657,960	2,657,960	2,657,960	2,657,960

TOTAL OTHER LIABILITIES	17,094,310	16,794,310	16,494,310	16,194,310	15,894,310	15,594,310	15,294,310	14,994,310	14,694,310	14,394,310	14,094,310	13,794,310
TOTAL LIABILITIES	75,637,124	76,227,897	75,936,190	75,044,877	75,701,153	75,880,373	74,056,833	74,257,391	74,463,016	74,665,245	74,860,727	75,058,261
STOCKHOLDER EQUITY												
CAPITAL STOCK, @PAR	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000
ADDTN'L PAID IN CAPITAL	39,400	39,400	39,400	39,400	39,400	39,400	39,400	39,400	39,400	39,400	39,400	39,400
UNREALIZED GAIN	54,188	54,188	54,188	54,188	54,188	54,188	54,188	54,188	54,188	54,188	54,188	54,188
RETAINED EARNINGS	7,273,756	7,895,896	8,425,219	8,949,270	9,426,834	9,951,835	10,538,802	11,140,964	11,743,311	12,322,333	12,868,727	13,406,929
TOTAL STOCKHOLDER EQUITY	7,393,344	8,015,484	8,544,807	9,068,858	9,546,422	10,071,423	10,658,390	11,260,552	11,862,899	12,441,921	12,988,315	13,526,517
TOTAL LIABILITIES &EQUITY	83,030,468	84,243,382	84,480,996	84,113,735	85,247,575	85,951,796	84,715,223	85,517,943	86,325,916	87,107,166	87,849,042	88,584,778